included in the data transmitted to CMS by fiscal intermediaries on or before April 5, 2002.

- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the January 2002 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 7, 2002) are incorporated into the final wage index in this final rule, to be effective October 1, 2002.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the fiscal intermediaries' attention. Moreover, because hospitals had access to the final wage data by early May 2002, they have had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the FY 2003 wage index in this final rule, and the implementation of the FY 2003 wage index on October 1, 2002. If hospitals availed themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after publication in the final rule, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(x)(2) of our existing regulations, we make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or CMS made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2003 (that is, by the June 7, 2002 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the fiscal intermediary notified the hospital of any changes, we do not expect that midyear corrections would be necessary. However, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is approved.

This policy for applying prospective corrections to the wage index was originally set forth in the preamble to the January 3, 1984 final rule (49 FR 258) implementing the hospital inpatient prospective payment system. It has been our longstanding policy to make midyear corrections to the hospital wage data and adjust the wage index for the affected areas on a prospective basis.

Section 412.63(x)(3) states that revisions to the wage index resulting from midyear corrections to the wage index values are incorporated in the wage index values for other areas at the beginning of the next Federal fiscal year. Prior to October 1, 1993, the wage index was based on a wage data survey submitted by all hospitals (prior to that, the data came from the Bureau of Labor Statistics' hospital wage and employment data file). Beginning October 1, 1993, as required by section 1886(d)(3)(E) of the Act, we began updating the wage index data on an annual basis. Because the wage index has been updated annually since FY 1994, § 412.63(x)(3) is no longer necessary, and in the May 9, 2002 proposed rule we proposed to delete it. Similarly, § 412.63(x)(4) provides that the effect on program payments of midyear corrections to the wage index values is taken into account in establishing the standardized amounts for the following year. Again, the wage data are now updated annually. Therefore, § 412.63(x)(4) is no longer necessary, and in the May 9, 2002 proposed rule we proposed to delete it as well.

Finally, we proposed to revise § 412.63(x)(2) to clarify that CMS will make a midyear correction to the wage index for an area only if a hospital can show that the intermediary or CMS made an error in tabulating the hospital's own data. That is, this provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index. As described above, the requesting hospital must show that it could not have known about the error, or that it did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

Comment: One commenter disagreed with the proposed revision to clarify § 412.63(x)(2). The commenter stated that the clarification that CMS will make a midyear correction to the wage index for an area only if a hospital can show that the intermediary or CMS made an error in tabulating the hospital's own data is illogical. The commenter believed that we should allow all potentially affected hospitals to report what they believe to be errors that they failed to correct before the beginning of the Federal fiscal year.

Response: We frequently instruct hospitals that they are responsible for reviewing their data and notifying the intermediary if there is an error or omission.

The proposed revision is consistent with the current rules in that it reinforces for hospitals the responsibility they have for assuring the accuracy of the wage data they submit.

The wage index is recalculated each year based on wage data from acute care hospitals nationwide. Since this calculation must be carried out on a nationwide basis, it is critical that we have the necessary data from all hospitals in a timely fashion so that the wage index values can be calculated prior to the beginning of the upcoming fiscal year. Accordingly, we set out well in advance a detailed timetable for reviewing and revising the data that hospitals, fiscal intermediaries, and CMS must follow. In this way, all hospitals are given an equal opportunity to review and correct their data within the established process. To further assist in the wage data review process, we require that fiscal intermediaries notify state hospital associations when a hospital fails to respond to issues raised during the wage data review process. The purpose of the notification is to inform the hospital association that its member hospital's failure to respond to matters raised by the fiscal intermediary can result in data being disallowed, thereby possibly lowering an area's wage index value. Consistent with out efforts to finalize the data used to construct the wage index prior to publication of the final rule, we make mid-year data revisions in only very limited circumstances, so that the disruptive effects of such changes can be avoided to the greatest extent possible. In turn, consistent with that principle, we think it is appropriate to limit such mid-year revisions to those pertaining only to the data of the requesting hospital. We do not believe this revision will unduly restrict the ability of hospitals to bring to our attention the need for revisions in a neighboring hospital's data; under our wage data revision process, hospitals have an ample opportunity to do this prior to the publication of the rule. Therefore, we disagree with the commenter that it is necessary or advisable to allow other hospitals an opportunity to request changes to a hospital's wage data after the final rule is published, and we are adopting our proposed changes as final.

Comment: One commenter representing Medicare fiscal intermediaries recommended that we revise the wage index development process to provide an incentive for hospitals to submit accurate wage data with their as-filed cost reports. The

commenter noted that, in the August 1, 2001 **Federal Register** (66 FR 39871), we implemented procedural changes that allow the intermediaries additional time to review hospital's wage data. In that rule, we indicated that wage data were revised between the publication of the proposed and final rules for 30 percent of the hospitals. To reduce this percentage, and the number of ''second'' desk reviews that intermediaries must perform when hospitals revise their wage data, the commenter recommended the following changes:

- CMS should publish an initial wage index public use file in September based on provider as-filed wage data.
- Hospitals should be allowed 4 weeks to review and submit to their intermediaries requests for corrections to the initial wage index public use file.
- After the hospitals 4-week review and correction request period, intermediaries should perform a single desk review of each hospital s wage data and make the appropriate requested corrections.
- After CMS publishes the reviewed final wage index file, hospitals should submit only corrections due to CMS' or the fiscal intermediary's mishandling of the wage data.

Response: We appreciate the commenter's recommendation, and we agree that revisions to the current wage index process should be considered to reduce duplicative review efforts. We will carefully explore options and their associated risks before making further refinements to the wage index development process.

IV. Rebasing and Revision of the Hospital Market Baskets

A. Operating Costs

1. Background

Effective for cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital ''market basket'') for operating costs. Although ''market basket'' technically describes the mix of goods and services used to produce hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket'' as used in this document refers to the hospital input price index.

The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchased in order to furnish inpatient care. We first used the market basket to adjust hospital cost limits by an amount that reflected the average increase in the prices of the goods and services used to furnish hospital inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the acute care hospital inpatient prospective payment system, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. A detailed explanation of the hospital market basket used to develop the prospective payment rates was published in the **Federal Register** on September 3, 1986 (51 FR 31461). We also refer the reader to the August 29, 1997 **Federal Register** (62 FR 45966) in which we discussed the previous rebasing of the hospital input price index. For FY 2003, payment rates will be updated by the projected increase in the hospital market basket minus 0.55 percentage points.

The hospital market basket is a fixed-weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then, the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. These price proxies are price levels derived from publicly available statistical series that are published on a consistent schedule, preferably at least on a quarterly basis.

Finally, the expenditure weight for each category is multiplied by the level of the respective price proxy. The sum of these products (that is, the expenditure weights multiplied by the price levels) for all cost categories yields the composite index level of the market basket in a given year. Repeating this step for other years produces a series of market basket index levels over time. Dividing one index level by an earlier index level produces rates of growth in the input price index over that time.

The market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital for use in providing inpatient care, but would not be factored into the price change measured by a fixed weight hospital market basket. In this manner, the index measures only the pure price change. Only rebasing (changing the base year) the index would capture these quantity and intensity effects in the market basket. Therefore, we rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) in furnishing inpatient care. We last rebased the hospital market basket cost weights in 1997, effective for FY 1998 (62 FR 45993). This market basket, used through FY 2002, reflects base year data from FY 1992 in the construction of the cost weights.

We note that there are separate market baskets for acute care hospital inpatient prospective payment system hospitals and excluded hospitals and hospital units. In addition, we are in the process of conducting the necessary research to determine if separate market baskets for the inpatient rehabilitation, long-term care, and psychiatric hospital prospective payment systems can be developed. However, for the purpose of this preamble, we are only discussing the market basket based on all excluded hospitals combined.

2. Rebasing and Revising the Hospital Market Basket

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, the base year cost structure for the prospective payment system hospital index shifts from FY 1992 to FY 1997). Revising means changing data sources, cost categories, or price proxies used in the input price index.

We used a rebased and revised hospital market basket in developing the FY 2003 update factor for the prospective payment rates. The rebased and revised market basket reflects FY 1997, rather than FY 1992, cost data. The 1997-based market baskets use data for hospitals from Medicare cost reports for cost reporting periods beginning on or after October 1, 1996, and before October 1, 1997. Fiscal year 1997 was selected as the new base year because 1997 is the most recent year for which relatively complete data are available. These include data from FY 1997 Medicare cost reports as well as 1997 data from two U.S. Department of

Commerce publications: the Bureau of the Census' Business Expenditure Survey (BES) and the Bureau of Economic Analysis' Annual Input-Output Tables. In addition, analysis of FYs 1998 and 1999 Medicare cost report data showed little difference in comparable cost shares from FY 1997 data.

In developing the rebased and revised market baskets set forth in the May 9, 2002 proposed rule (67 FR 31438) and adopted in this final rule, we used hospital operating expenditure data in determining the market basket cost weights. We relied primarily on Medicare hospital cost report data for the rebasing. We prefer to use cost report data wherever possible because these are the cost data supplied directly from hospitals. Other data sources such as the BES and the input-output tables serve as secondary sources used to fill in where cost report data are not available or appear to be incomplete. We are providing the following detailed discussion of the process for calculating cost share weights.

Cost category weights for the FY 1997-based market baskets were developed in several stages. First, base weights for several of the operating cost categories (Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, and Blood and Blood Products) were derived from the FY 1997 Medicare cost reports. The expenditures for these categories were calculated as a percentage of total operating costs from those hospitals covered under the inpatient hospital prospective payment system. These data were then edited to remove outliers and ensure that the hospital participated in the Medicare program and had Medicare costs. However, we were unable to measure only those operating costs attributable to the inpatient portion of the hospital because many of the hospitals' cost centers are utilized for both inpatient and outpatient care. Health Economics Research (HER), under contract with CMS, just recently completed a feasibility study on the construction of a separate outpatient market basket for our outpatient hospital prospective payment system. While this research provided some insight about ways to separate inpatient and outpatient costs, HER also found that substantially more data would need to be collected from hospitals in order to accomplish this. Furthermore, we excluded hospital-based subprovider cost centers (for example, skilled nursing, nursing, hospice, psychiatric, rehabilitation, intermediate care/mental retardation, and other long-term care) as well as the portion of overhead and ancillary costs incurred by these subproviders.

Second, the weight for professional liability insurance was calculated using data from a survey conducted by ANASYS under contract to CMS. This survey, called the National Hospital Malpractice Insurance Survey (NHMIS), was conducted to estimate hospital malpractice insurance costs over time at the national level. A more detailed description of this survey is found later in this preamble.

Third, data from the 1997 Business Expenditure Survey (BES) was used to develop a weight for the utilities and telephone services categories. Like most other data sources, the BES includes data for all hospitals and does not break out data by payor. However, we believe the overall data from the BES does not produce results that are inconsistent with the prospective payment system hospitals, particularly at the detailed cost category level with which we are working.

Fourth, the sum of the weights for wages and salaries, employee benefits, contract labor, professional liability insurance, utilities, pharmaceuticals, blood and blood products, and telephone services was subtracted from operating expenses to obtain a portion for all other expenses.

Finally, the weight for all other expenses was divided into subcategories using relative cost shares from the 1997 Annual Input-Output Table for the hospital industry, produced by the Bureau of Economic Analysis, U.S. Department of Commerce. The 1997 Benchmark Input-Output data will be available, at the earliest, in late 2002, so we are unable to incorporate these data in this final rule.

Comment: Several commenters mentioned the need for an improved market basket, where the composition of the market basket is a more contemporary reflection of the cost pressures hospitals are facing. They suggest that we rebase more frequently than the current interval of approximately every 5 years.

Response: As explained in the May 9, 2002 proposed rule (67 FR 31439), FY 1997 was selected as the base year for the revised and rebased hospital market basket because it is the most recent year for which relatively complete data are available.

It is important to realize that the Medicare cost reports were used as the primary source of data because these data were supplied directly from hospitals. The independent secondary sources such as the BES and the input-output table fill in where cost report data were not available or appeared to be incomplete. While the major cost categories are available for a more recent year from the cost reports, the additional detail derived from the input-output tables and the BES was not, as the Bureau of the Census only publishes these data for 5-year intervals. In addition, the major cost category weights determined using the FY 1997 Medicare cost reports were compared to weights calculated using FY 1998 and FY 1999 Medicare cost reports. These results were then compared to the weights calculated from the 1997 Medicare cost reports. The results were very similar to those calculated using FY 1997 Medicare cost report data. Thus, 1997 data are the most recent, complete, and consistent data readily available for our rebasing work this year, and using more recent data woud not produce dissimilar results.

Below, we further describe the sources of the six main category weights and their subcategories in the FY 1997-based market basket while noting the differences between the methodologies used to develop the FY 1992-based and the FY 1997-based market baskets.

- *Wages and Salaries:* The cost weight for the wages and salaries category was derived using Worksheet S–3 from the FY 1997 Medicare cost reports. Contract labor, which is also derived from the FY 1997 Medicare cost reports, is split between the wages and salaries and employee benefits cost categories, using the relationship for employed workers. An example of contract labor is registered nurses who are employed and paid by firms that contract for their work with the hospital. The wages and salaries category in the FY 1992-based market basket was developed from the FY 1992 Medicare cost reports. In addition, we used the 1992 Current Population Survey to break out more detailed occupational subcategories. These subcategories were not broken out for the FY 1997-based market basket.
- *Employee Benefits:* The cost weight for the employee benefits category was derived from Worksheet S–3 of the FY 1997 Medicare cost reports. The employee benefits category in the FY 1992-based market basket was developed from FY 1992 Medicare cost reports and we used the 1992 Current Population Survey to break out various occupational subcategories. These subcategories were not broken out for the FY 1997-based market basket.
- *Nonmedical Professional Fees:* This category refers to various types of nonmedical professional fees such as legal, accounting, engineering, and management and consulting fees. Management and consulting and legal

fees make up the majority of professional fees in the hospital sector. The cost weight for the nonmedical professional fees category was derived from the Bureau of Economic Analysis Input-Output data for 1997. The FY 1992-based index used a combination of data from the American Hospital Association (AHA) and the Medicare cost reports to arrive at a weight. However, because the AHA survey data for professional fees are no longer published, we were unable to duplicate this method. Had we used the FY 1997-based methodology to calculate the FY 1992 nonmedical professional fees component, the proportion would have been similar to the FY 1997 share.

• *Professional Liability Insurance:* The FY 1997-based market basket uses a weight for professional liability insurance derived from a survey conducted by ANASYS under contract to CMS (Contract Number 500–98–005). This survey attempted to estimate hospital malpractice insurance costs over time at the national level for years 1996 and 1997. The population universe of the survey was defined as all non-Federal, short-term, acute care prospective payment system hospitals. A statistical sample of hospitals was drawn from this universe and data collected from those hospitals. This sample of hospitals was then matched to the appropriate cost report data so that a malpractice cost weight could be calculated. The questions used in the survey were based on a 1986 General Accounting Office (GAO) malpractice survey questionnaire that was modified so data could be collected to calculate a malpractice cost weight and the rate of change for a constant level of malpractice coverage at the national level. The 1997 proportion as calculated by ANASYS was compared to limited data for FYs 1998 and 1999 contained in the Medicare Cost Reports System. The percentages are relatively comparable. However, since this field was virtually incomplete in the FY 1997 cost report file, we were unable to use this cost report data.

In contrast, the FY 1992-based market basket professional liability insurance weight was determined using the cost report data for PPS–6 (cost reporting periods beginning in FY 1989), the last year these costs had to be treated separately from all other administrative and general costs, trended forward to FY 1992 based on the relative importance of malpractice costs found in the previous market basket.

Comment: A few commenters indicated that the explanation provided for the derivation of the professional liability insurance weight does not convey a full understanding of the methodology and data used; they would like additional information. They also questioned the appropriateness of assuming a constant level of malpractice coverage at a national level across time when updating this weight.

Response: We believe the method for calculating the weight for professional liability insurance in the hospital market basket is reasonable given the alternatives we examined. The weight for professional liability insurance was derived from a survey conducted by ANASYS for CMS called the National Hospital Malpractice Insurance Survey (NHMIS). This survey was designed to collect hospital malpractice insurance costs of primary and excess coverage as well as deductible and other costs for 1996 and 1997. The survey collected malpractice information directly from a representative sample of hospitals derived from a universe defined as all non-Federal short-term acute care prospective payment system hospitals. The hospitals were sent a questionnaire derived from a 1986 General Accounting Office Survey. Follow-up phone calls were made where necessary resulting in a total response rate to the survey was 67 percent. After the data were collected, several edits were run to test the validity and reasonableness of the data. The total malpractice cost was derived by adding the adjusted primary and excess premiums, deductible costs, and other costs. The survey hospitals were then matched to the corresponding Medicare cost reports to derive a total hospital cost using the malpractice insurance policy year and hospital fiscal year as matching variables. The total professional liability insurance cost for each hospital calculated from the survey was then divided by the total hospital costs calculated from the Medicare cost reports to arrive at a weight for professional liability insurance for the hospital. The mean cost weight of all of the hospital weights was then used as the professional liability insurance weight.

Other methods, such as using the Medicare cost reports or trending 1992 data forward, presented significant data limitations. We were unable to use the Medicare cost report data in the development of a weight because 1997 data were incomplete, with very few hospitals submitting information on professional liability insurance. We compared weights derived from 1998 and 1999 cost report data, which were much more complete than 1997 data, and found that they produced results very similar to the weight calculated in the ANASYS report. We were also unable to use the prior method of calculating a professional liability insurance weight by trending 1992 data forward. This method would only capture the effect of price changes over time and would not reflect increases or decreases in the quantities of professional liability insurance purchased that should be reflected in the cost category weight. In the development of the 1992-based market basket, the method used was the only available option. Therefore, given the data available from ANASYS and the limitations of other methods we considered, we believe that the method of calculating a weight chosen was reasonable.

To address the commenters' second point, we feel that it is appropriate to assume a constant level of malpractice coverage at a national level. By doing so, we are able to capture only the 'pure' price change in professional liability premiums and not the additional effect of increasing or decreasing liability coverage. This method is consistent with the methods used by Bureau of Labor Statistics (BLS) in constructing its Producer Price Indexes (PPIs).

Comment: Several commenters believe that we should explicitly account for other insurance categories such as property and general liability insurance in the market basket and not just professional liability insurance because of large premium increases in those categories. In addition, the commenters believe that we should adjust the weight given to insurance, blood products, and other items that experience extraordinary price increases.

Response: The market basket implicitly accounts for increases in other insurance categories under the All Other-Labor Intensive Services category. We are unable to separate out other detailed insurance categories in the market basket due to data limitations. A publicly available data source that meets our criteria for developing weights for these other insurance categories does not exist at this time. In addition, data for price proxies such as the BLS PPI for property and casualty insurance show similar price movements to those of the All Other-Labor Intensive category in the market basket.

In addition, we cannot inflate the weights of some categories and not others. This would violate the general principles of price index construction. We have compiled data for all of the cost categories in addition to total costs for a common base year and developed a set of weights that are consistent with respect to the principles of price index construction. Attempting to reflect more

recent trends in some categories and not in others would not accurately capture the entire cost structure that hospitals face at a given time. In addition, while expenditures for a category may be increasing, this may not necessarily lead to a greater weight for that category in the market basket. For example, property insurance expenditures could be increasing, but other categories could be increasing faster, so that the weight for property insurance in the market basket would be declining. Thus, it is necessary that all of the weights are reflective of a consistent base year.

• *Utilities:* For the FY 1997-based market baskets, the cost weight for utilities is derived from the Bureau of the Census' Business Expenditures Survey. For the FY 1992-based market baskets, the cost weight for utilities was derived from the Bureau of the Census' Asset and Expenditures Survey. Even though the Business Expenditure Survey replaced the Asset and Expenditure Survey, the categories and results are still similar.

• *All Other Products and Services:* The all other products and services category includes the remainder of products and services that hospitals purchase in providing care. Products found in this category include: direct service food, contract service food, pharmaceuticals, blood and blood products, chemicals, medical instruments, photographic supplies, rubber and plastics, paper products, apparel, machinery and equipment, and miscellaneous products. Services found in this category include: telephone, postage, other labor-intensive services, and other nonlabor-intensive services. Labor-intensive services include those services for which local labor markets would likely influence prices.

The shares for pharmaceuticals and blood and blood products are derived from the FY 1997 Medicare cost reports, while the share for telephone services was derived from the BES. Relative shares for the other subcategories are derived from the 1997 Bureau of Economic Analysis Annual Input-Output Table for the hospital industry. The calculation of these subcategories involved calculating a residual from the Input-Output Table using categories similar to those not yet accounted for in the market basket. Subcategory weights were then calculated as a proportion of this residual and applied to the similar residual in the market basket.

• *Blood and blood products:* When the market basket was last revised and rebased to FY 1992, the component for blood services was discontinued because of the lack of appropriate data to determine a weight. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) required that we consider the prices of blood and blood products purchased by hospitals and determine whether those prices are adequately reflected in the market basket. In accordance with this requirement, we have done considerable research to determine if a component for blood and blood products should be added to the market basket and, if so, how the weight should be determined. We studied four alternative data sources to possibly determine a weight for blood in the market basket. If none of these data sources were deemed acceptable, we could conclude that a component for blood should not be reintroduced in the hospital market basket. In its December 2001 report entitled ''Blood Safety in Hospitals and Medicare Inpatient Payment,'' MedPAC recommended that the market basket should explicitly account for the cost of blood and blood products by reintroducing a separate component for their prices.

The first alternative data source studied was using data from the Medicare cost reports. The cost reports have two cost centers where the costs of blood can be recorded: (1) Whole blood and packed red blood cells (nonsalary); and (2) blood storing, processing, and transfusion (nonsalary). Although all prospective payment system hospitals submit a cost report, less than half of these hospitals reported data in either of the two blood cost centers. However, if we can determine that the hospitals reporting blood are representative of all prospective payment system hospitals, then a cost share can be computed using the cost reports.

The second alternative involves constructing weights from the Input-Output Table from the BEA, Department of Commerce. These data were used to construct the weight when the market basket was revised before FY 1992. Unfortunately, BEA stopped reporting blood separately in their Input-Output Table in 1987. One possible use of these data would be to calculate a weight by updating the prior weight by the relative price change for blood between the last data point available and 1997. However, by using this method, only the escalation in prices, not the changes in quantity or intensity of use of blood products, would be captured.

The third alternative was using data from the MedPAR files. This option was discussed in MedPAC's December 2001 report, and involves using claims data or data on hospital charges. In order to construct a weight for the market basket, the underlying costs of blood must be calculated from the claims data. An analysis of cost-to-charge ratios of hospitals can determine if this is feasible.

The final alternative data source is the Bureau of the Census' quinquennial Business Expenditure Survey and the Economic Census. A weight can be obtained indirectly by taking the ratio of receipts of nonprofit blood collectors to total operating expenses of hospitals. Some adjustments would be needed in order for the weight calculated in this way to be completely valid. In addition, this method assumes that all blood used by hospitals comes from nonprofit sources. However, in 1999, hospitals collected 7 percent of the donated units.

After a thorough analysis, we have determined that the Medicare cost reports, after minor adjustments, are the best option. The data from the Input-Output Table are not optimal because they are not current and would have to be aged using only price data, which do not reflect quantity and intensity changes over this period. Although the MedPAR data could be adjusted to compute a cost share, using claims data is not the preferred alternative. Census data would be an attractive option if the cost reports were not available.

The main weakness of the Medicare cost reports is the inconsistent reporting of hospitals in the two blood cost centers. In 1997, only 48.0 percent of all hospitals reported blood in one or both cost centers. However, these hospitals accounted for 62.2 percent of the operating costs of all hospitals. In order for the calculation of the blood cost share weight to be acceptable, the hospitals that reported blood would need to be adjusted to be representative of all hospitals, including those that did not report blood on the cost reports.

Because of the similarity of data in the two blood cost centers, the assumption was made that if a hospital reported blood in only one of the two cost centers, all of its blood costs were reported in that cost center. In the FY 1997 cost reports, of the hospitals that reported blood, 41.3 percent reported only in the blood cells cost center, 58.2 percent reported only in the blood storing cost center, and only 0.5 percent reported in both blood cost centers. To calculate a weight, the numerator was the summation of the data in both blood cost centers. The denominator was the summation of the operating costs of each hospital that reported blood in each cost center minus the operating costs of the few hospitals that reported blood in both cost centers to avoid double counting.

The blood cost share calculated from these data was then adjusted so that the hospitals reporting blood had the same

characteristics of all other hospitals. Adjustments were necessary because the hospitals that reported blood were more likely to be urban and teaching hospitals than those hospitals that did not report blood. The adjustments made less than a 0.1 percent difference in the cost share.

The weight produced using the FY 1997 cost reports was 0.875 percent. We also looked at cost report data from FYs 1996 and 1998. The weights calculated in these years were similar to the FY 1997 weight. The calculation of the blood cost share using the alternative data sources cited above was similar to the results using the cost reports. In this final rule, we use the Medicare cost reports to determine a weight for blood and blood products in the hospital market basket given the consistency with these other sources, the representativeness of our estimate, and the stability of the cost share.

Overall, our work resulted in the identification of 23 separate cost categories in the rebased and revised hospital market basket. There is one more category than was included in the FY 1992-based market basket (FY 1992-based had 22 categories). The differences between the weights of the major categories determined from the Medicare cost reports for the FY 1997-based index and the previous FY 1992-based index are summarized in Table 1.

TABLE 1.—FY 1992-BASED AND FY 1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING MAJOR COST CATEGORIES AND WEIGHTS AS DETERMINED FROM THE MEDICARE COST REPORTS

Expense categories	Rebased FY 1997-based hospital market basket	FY 1992-Based hospital market basket
Wages and Salaries	50.686	50.244
Employee Benefits	10.970	11.146
Pharmaceuticals	5.416	4.162
Blood and Blood Products	0.875	.....
All Other	32.053	34.448
Total	100.000	100.000

Table 2 sets forth all of the market basket cost categories and weights. For comparison purposes, the 1992-based cost categories and weights are included in the table.

TABLE 2.—FY 1992-BASED AND FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS

Expense categories	Rebased FY 1997-based hospital market basket weights	FY 1992-based hospital market basket weights
1. Compensation	61.656	61.390
A. Wages and Salaries	50.686	50.244
B. Employee Benefits	10.970	11.146
2. Professional Fees	5.401	2.127
3. Utilities	1.353	1.542
A. Fuel, Oil, and Gasoline	0.284	0.369
B. Electricity	0.833	0.927
C. Water and Sewerage	0.236	0.246
4. Professional Liability Insurance	0.840	1.189
5. All Other	30.749	33.752
A. All Other Products	19.537	24.825
(1.) Pharmaceuticals	5.416	4.162
(2.) Direct Purchase Food	1.370	2.314
(3.) Contract Service Food	1.274	1.072
(4.) Chemicals	2.604	3.666
(5.) Blood and Blood Products	0.875	.....
(6.) Medical Instruments	2.192	3.080
(7.) Photographic Supplies	0.204	0.391
(8.) Rubber and Plastics	1.668	4.750
(9.) Paper Products	1.355	2.078
(10.) Apparel	0.583	0.869
(11.) Machinery and Equipment	1.040	0.207
(12.) Miscellaneous Products	0.956	2.236
B. All Other Services	11.212	8.927
(1.) Telephone Services	0.398	0.581
(2.) Postage	0.857	0.272
(3.) All Other: Labor Intensive	5.438	7.277
(4.) All Other: Non-Labor Intensive	4.519	0.796
Total	100.000	100.000

Note: Due to rounding, weights may not sum to total.

3. Selection of Price Proxies

After computing the FY 1997 cost weights for the rebased and revised hospital market basket, it was necessary to select appropriate wage and price proxies for each expenditure category. Most of the indicators are based on BLS data and are grouped into one of the following BLS categories:

• Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because a PPI would better reflect the prices faced by hospitals. For example, we used the PPI for ethical (prescription) drugs, rather than the Consumer Price Index (CPI) for prescription drugs, because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we use measure price changes at the final stage of production.

• Consumer Price Indexes—Consumer Price Indexes (CPIs) measure price changes of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, the consumer price indexes were used only if an appropriate PPI was not available or if the expenditure was more similar to that of retail consumers in general rather than wholesale purchasers. For example, the CPI for food purchased away from home was used as a proxy for contracted food services.

• Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are appropriately not affected by shifts in skill mix.

Table 3 sets forth the complete hospital market basket including cost categories, weights, and price proxies. For comparison purposes, we also list the respective FY 1992-based market basket price proxies. A summary outlining the choice of the various proxies follows the table.

TABLE 3.—FY 1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS, AND FY 1992-BASED AND FY 1997-BASED PRICE PROXIES

Expense categories	Rebased FY 1997 hospital market basket weights	Rebased FY 1997 hospital market basket price proxy	FY 1992 hospital market basket price proxy
1. Compensation	61.656		
Wages and Salaries	50.686	ECI-Wages and Salaries, Civilian Hospital Workers.	CMS Occupational Wage Proxy
Employee benefits	10.970	ECI-Benefits, Civilian Hospital Workers	CMS Occupational Benefit Proxy
2. Professional Fees	5.401	ECI-Compensation for Professional, Specialty & Technical.	ECI-Compensation for Professional, Specialty & Technical
3. Utilities	1.353		
A. Fuel, Oil, And Gasoline	0.284	PPI Commercial Natural Gas	PPI Commercial Natural Gas
B. Electricity	0.833	PPI Commercial Electric Power	PPI Commercial Electric Power
C. Water and Sewerage	0.236	CPI–U Water & Sewerage Maintenance.	CPI–U Water & Sewerage Maintenance
4. Professional Liability Insurance	0.840	CMS Professional Liability Insurance Premium Index.	CMS Professional Liability Insurance Premium Index
5. All Other	30.749		
All Other Products	19.537		
(1.) Pharmaceuticals	5.416	PPI Ethical (Prescription) Drugs	PPI Ethical (Prescription) Drugs
(2.) Direct Purchase Food	1.370	PPI Processed Foods & Feeds	PPI Processed Foods & Feeds
(3.) Contract Service Food	1.274	CPI–U Food Away From Home	CPI–U Food Away From Home
(4.) Chemicals	2.604	PPI Industrial Chemicals	PPI Industrial Chemicals
(5.) Blood and Blood Products	0.875	PPI Blood and Blood Derivatives, Human Use.	N/A
(6.) Medical Instruments	2.192	PPI Medical Instruments & Equipment	PPI Medical Instruments & Equipment
(7.) Photographic Supplies	0.204	PPI Photographic Supplies	PPI Photographic Supplies
(8.) Rubber and Plastics	1.668	PPI Rubber & Plastic Products	PPI Rubber & Plastic Products
(9.) Paper Products	1.355	PPI Converted Paper & Paperboard Products.	PPI Converted Paper & Paperboard Products
(10.) Apparel	0.583	PPI Apparel	PPI Apparel
(11.) Machinery and Equipment.	1.040	PPI Machinery & Equipment	PPI Machinery & Equipment
(12.) Miscellaneous Products	0.956	PPI Finished Goods less Food and Energy.	PPI Finished Goods
B. All Other Services	11.212		
(1.) Telephone Services	0.398	CPI–U Telephone Services	CPI–U Telephone Services
(2.) Postage	0.857	CPI–U Postage	CPI–U Postage
(3.) All Other: Labor Intensive	5.438	ECI-Compensation for Private Service Occupations.	ECI-Compensation for Private Service Occupations
(4.) All Other: Non-Labor Intensive.	4.519	CPI–U All Items	CPI–U All Items
Total	100.000		

Note: Totals may not sum to 100 due to rounding.

a. Wages and Salaries

For measuring the price growth of wages in the FY 1997-based market basket, we use the ECI for civilian hospitals. This differs from the proxy used in the FY 1992-based index in which a blended occupational wage index was used. The blended occupational wage proxy used in the FY 1992-based index and the ECI for wages and salaries for hospitals both reflect a fixed distribution of occupations within the hospital. The major difference between the two proxies is in the treatment of professional and technical wages. In the blended occupational wage proxy, the professional and technical category was blended evenly between the ECI for wages and salaries for hospitals and the ECI for wages and salaries for professional and technical occupations in the overall economy, instead of hospital-specific occupations as reflected in the ECI for hospitals. This blend was done to create a normative price index that did not reflect the market imperfections in the hospital labor markets that existed for much of the 1980s and early 1990s.

Between 1987 (the first year the ECI for hospitals was available, although the pattern existed before then using other measures of hospital wages) and 1994, the ECI for wages and salaries for hospital workers grew faster than the blended occupational wage proxy. During the period from 1995 through 2000, this trend reversed; each year the ECI grew slower than the blended occupational wage proxy. This is the apparent result of the shift of private insurance enrollees from fee-for-service plans to managed care plans and the tighter controls these plans exhibited over hospital utilization and incentives to shift care out of the inpatient hospital setting. More recently, the ECI for wages and salaries for hospital workers has again grown faster than the blended occupational wage proxy, raising the question of whether the relationship between hospital wages and the occupational wage blend from 1994 through 2000 was the signaling of a new era in the competitiveness of the hospital labor market, or simply the temporary reversal of the long-term pattern of labor market imperfections in hospitals.

In order to answer this question, we researched the historical determinants of this relationship and estimated what the future market conditions are likely to be. Our analysis indicated that the driving force behind the long-term differential between hospital wages and the blended occupational wage proxy was the increased demand for hospital services and the subsequent increase in hospital utilization, particularly in outpatient settings. However, during the 1994 through 2000 period, the major force behind the reversal of the differential was the shift of enrollees to managed care plans that had tighter restrictions on hospital utilization and encouraged the shift of care out of the hospital setting. To a lesser extent, the robust economic growth and tight economy-wide labor markets that accompanied this period helped to reverse the differential as well. Over the last few years, there has been a move back towards less restrictive plans, and a subsequent increase in the utilization of hospital services. This recent surge appears to reflect the true underlying effect of rising health care demand.

This concept is reinforced by the similar patterns being observed for nursing homes and other health sectors as well. This is an important development, specifically when compared to the ECI for wages and salaries for nursing homes, which reflect less skilled occupations, yet still experienced a similar acceleration in wage growth. Thus, we would expect that this recent surge in hospital wages is reflective of competitive labor market conditions, and would likely persist only as long as the underlying demand for health care was accelerating.

While the shift to managed care plans had a noticeable one-time effect, our analysis has indicated that the hospital labor market is more competitive than before this period and that the expected shift towards more restrictive insurance plans over the coming decade will act to create a wage differential that reflects the underlying increases in demand for hospital services. For FY 2003, the hospital market basket is forecast to increase 0.2 percentage points faster (3.5 versus 3.3) than it would have if the occupational blend had been used. Based on this, we use the ECI for wages and salaries for hospitals as the proxy in the hospital market basket for wages. The ECI met our criteria of relevance, reliability, availability, and timeliness. Relevance means that the proxy is applicable and representative of the cost category that it proxies. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Availability means that the proxy is publicly available. Timeliness implies that the proxy is published regularly, at least quarterly.

b. Employee Benefits

The FY 1997-based hospital market basket uses the ECI for employee benefits for civilian hospitals. This differs from the FY 1992-based index in which a blended occupational index was used. Our conclusions were based on an analysis similar to that done for the wages and salaries proxy described above.

c. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry is applied to this category since it includes occupations such as management and consulting, legal, accounting, and engineering services. The same price measure was used in the FY 1992-based market basket.

d. Fuel, Oil, and Gasoline

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) is applied to this component. The same price measure was used in the FY 1992-based market basket.

e. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) is applied to this component. The same price measure was used in the FY 1992-based market basket.

f. Water and Sewerage

The percentage change in the price of water and sewerage maintenance as measured by the Consumer Price Index (CPI) for all urban consumers (CPI Code #CUUR0000SEHG01) is applied to this component. The same price measure was used in the FY 1992-based market basket.

g. Professional Liability Insurance

The percentage change in the hospital professional liability insurance price as estimated by the CMS Hospital Malpractice Index is applied. In the FY 1992-based market basket, the same proxy was used.

We are currently conducting research into improving our proxy for professional liability insurance. This research includes subcontracting with ANASYS through a contract with DRI–WEFA to extend the results of its NHMIS survey to set up a sample of hospitals from which malpractice insurance premium data will be directly collected. This new information, which would include liability estimates for hospitals that self-insure, would be combined with our current proxy data to obtain a more accurate price measure. In addition, we continue to monitor a BLS PPI for medical malpractice premiums that in the future could be used as a proxy for this cost category.

Comment: Several commenters indicated that hospital malpractice costs are increasing much faster than the professional liability portion of the market basket and we should consider other alternatives.

Response: We believe that our price proxy for professional liability insurance adequately measures the increases in professional liability insurance costs facing hospitals. While anecdotal evidence suggests that malpractice costs are increasing at double-digit rates, actual data as measured by the CMS hospital professional liability insurance survey as well as data on insurance from the BLS Producer Price Index through 2001 do not reflect this. Since the FY 2003 market basket increase is based on a forecast from DRI–WEFA, the expected trends in hospital professional liability insurance premiums are indeed reflected. As is the case with all of our indexes, we regularly review all of the proxies in the index to verify that they are representative of current industry trends. In addition, as mentioned in the May 9, 2002 proposed rule (67 FR 31444), we are currently exploring alternatives to our price proxy for hospital professional liability insurance including possibly using the BLS Producer Price Index for medical malpractice. We are also working with our contractor to explore possible methods of improving our hospital professional liability proxy, though this research is not yet complete.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (Commodity Code #PPI283D#RX) is applied to this variable. This is a special index produced by BLS. The previous price proxy used in the FY 1992-based index (Commodity Code #0635) was discontinued after BLS revised its indexes.

i. Food, Direct Purchases

The percentage change in the price of processed foods as measured by the PPI (Commodity Code #02) is applied to this component. The same price measure was used in the FY 1992-based market basket.

j. Food, Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEFV) is applied to this component. The same price measure was used in the FY 1992-based market basket.

k. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) is applied to this component. While the chemicals hospitals use include industrial as well as other types of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus, Commodity Code #061 is the appropriate proxy. The same price measure was used in the FY 1992-based market basket.

l. Blood and Blood Products

The percentage change in the price of blood and derivatives for human use as measured by the PPI (Commodity Code #063711) is applied to this component. As discussed earlier in this preamble, a comparable cost category was not available in the FY 1992-based market basket.

We use the PPI for blood and blood derivatives as the price proxy for the blood and blood products cost category. This proxy is relevant, reliable, available, and timely. We considered placing the blood weight in the Chemicals or Pharmaceuticals cost category, but found this made only minor changes to the total index. We also considered constructing an index based on blood cost data received from the American Red Cross, America's Blood Centers, and Zeman and Company. However, these data are collected annually and are not widely available. The PPI for blood and blood derivatives was the only index we found that met all of our criteria.

Comment: Several commenters supported the separate expense category for blood and blood products in the market basket and the use of the PPI for blood and blood derivatives for human use as the price proxy for monitoring the rate of change in blood costs. However, the commenters indicated that it is important to ensure that the PPI for blood and blood derivatives is appropriately and timely updated by the BLS so that it adequately tracks changing blood technologies and safety initiatives. The commenters added that ensuring the safety of the nation's blood supply requires constant attention to developing disease states and testing technologies and creates changing costs that must be captured by the blood PPI to ensure adequate reflection in the prospective payment system market basket.

Response: We agree that the PPI for blood and blood derivatives should appropriately reflect the price of blood and blood products. We will continue to monitor the PPI to ensure that this is the case. We are supportive of efforts by the BLS to collect the necessary information on the price of blood and blood products so they are accurately reflected in the PPI for blood and blood derivatives. Organizations that represent blood providers are also encouraged to work with BLS to accomplish this goal.

Comment: One commenter suggested that we use data from the Red Cross, America's Blood Centers or Zeman and Company in developing a price proxy that reflects recent cost increases for blood products.

Response: We require that all price indexes used in our market baskets to be relevant, reliable, available, and timely. The BLS PPI for blood and blood derivatives is an independent estimate of prices for these products that are published on a regular schedule (monthly). It is based on sound statistical methods and meets our criteria listed above. The possible sources of data mentioned by the commenter are not available frequently enough and on a regular basis and, therefore, do not meet the criterion of timeliness. Also, it has not been determined if indexes based on these data would be relevant or reliable enough for use in the CMS market baskets. Furthermore, because of their method of construction, the BLS indexes that we use as price proxies in the market baskets reflect only the effect of price changes and not the effects of quantity or quality changes. Our market baskets are designed to measure only the price change effects on increases in costs and not the quantity or quality effects. It has not been demonstrated whether indexes from these other data sources would capture only price effects or whether they mix price and quantity/quality effects.

m. Surgical and Medical Equipment

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) is applied to this component. The same price measure was used in the FY 1992-based market basket.

n. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) is applied to this component. The same price measure was used in the FY 1992-based market basket.

o. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) is applied to this component. The same

price measure was used in the FY 1992-based market basket.

p. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) is used. The same price measure was used in the FY 1992-based market basket.

q. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) is applied to this component. The same price measure was used in the FY 1992-based market basket.

r. Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) is applied to this component. The same price measure was used in the FY 1992-based market basket.

s. Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) is applied to this component. The percentage change in the price of all finished goods was used in the FY 1992-based market basket. This change was made to remove the effect of food and energy prices, which are already captured elsewhere in the market basket.

t. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEED) is applied to this component. The same price measure was used in the FY 1992-based market basket.

u. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEEC01) is applied to this component. The same price measure was used in the FY 1992-based market basket.

v. All Other Services, Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry is applied to this component. The same price measure was used in the FY 1992-based market basket.

w. All Other Services, Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers (CPI Code #CUUR0000SA0) is applied to this component. The same price measure was used in the FY 1992-based market basket.

For further discussion of the rationale for choosing many of the specific price proxies, we reference the August 30, 1996 final rule (61 FR 46326). Table 4 shows the historical and forecasted updates under both the FY 1997-based and the FY 1992-based market baskets.

TABLE 4.—FY 1992-BASED AND FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004

Fiscal year (FY)	Rebased 1997-based hospital market basket	FY 1992-based market basket
Historical Data:		
FY 1995	2.8	3.1
FY 1996	2.3	2.4
FY 1997	1.6	2.1
FY 1998	2.7	2.9
FY 1999	2.7	2.5
FY 2000	3.3	3.6
FY 2001	4.3	4.1
Average FYs 1995–2001	2.8	3.0
Forecast:		
FY 2002	3.9	3.0
FY 2003	3.5	3.2
FY 2004	3.1	3.2
Average FYs 2002–2004	3.5	3.1

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM

As indicated by Table 5, switching the proxy for wages and benefits to the ECI for Civilian Hospitals has a minimal effect over time. While the FY 2003 update is 0.2 percentage points higher than using the previous blended occupational wage proxy, we believe that it is a more appropriate measure of price change in hospital wages and benefit prices given the current labor market conditions facing hospitals.

TABLE 5.—1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004

Fiscal year (FY)	Rebased 1997 hospital market basket using ECIs for wages and benefits	Rebased 1997 market basket using occupational wage and benefit proxies
Historical Data:		

TABLE 5.—1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004—Continued

Fiscal year (FY)	Rebased 1997 hospital market basket using ECIs for wages and benefits	Rebased 1997 market basket using occupational wage and benefit proxies
FY 1995	2.8	3.0
FY 1996	2.3	2.5
FY 1997	1.6	2.2
FY 1998	2.7	3.2
FY 1999	2.7	3.0
FY 2000	3.3	3.4
FY 2001	4.3	4.1
Average FYs 1995–2001	2.8	3.1
Forecast:		
FY 2002	3.9	3.3
FY 2003	3.5	3.3
FY 2004	3.1	3.3
Average FYs 2002–2004	3.5	3.3

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM

4. Labor-Related Share

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act direct the Secretary to estimate from time to time the proportion of payments that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *.'' The labor-related share is used to determine the proportion of the national prospective payment system base payment rate to which the area wage index is applied. In the past, we have defined the labor-related share for prospective payment system acute care hospitals as the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. The labor-related share for the acute care hospital inpatient prospective payment system market basket has been the sum of the weights for wages and salaries, fringe benefits, professional fees, contract labor, postage, business services, and labor-intensive services.

In its June 2001 Report to Congress, MedPAC recommended that ''To ensure accurate input-price adjustments in Medicare's prospective payment systems, the Secretary should reevaluate current assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets.'' (Report to the Congress: Medicare in Rural America, p. 80, Recommendation 4D.) MedPAC believes that the labor-related share is an estimate of the national average proportion of providers' costs associated with inputs that are only affected by local market wage levels. MedPAC recommended the labor-related share include the weights for wages and salaries, fringe benefits, contract labor, and other labor-related costs for locally purchased inputs only. By changing the methodology, and thereby lowering the labor-related share, funds would be transferred from urban to rural hospitals, which generally have wage index values less than 1.0.

Our proposed methodology was consistent with that used in the past to determine the labor-related share, which is the summation of the cost categories from the market basket deemed to vary with the local labor market. However, we noted that, while we did not propose to change the methodology for calculating the labor-related share in the proposed rule, we have begun the research necessary to reevaluate the current assumptions used in determining this share. This reevaluation is consistent with MedPAC's recommendation in their June 2001 report. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or just a portion of professional fees and nonlabor intensive services should be considered labor-related.

We also noted our concern that the result of our methodology (increasing the labor-related share from 71.066 percent to 72.495 percent) could have negative impacts that would fall predominantly on rural hospitals. In addition, we noted that we planned to conduct further research and would make the appropriate changes in the final rule if another methodology was found to be superior to our current methodology.

Comment: Commenters generally supported our expressed willingness to review this methodology, and emphasized the need for a full and careful study of any changes before adopting major changes. Comments on behalf of some national and State hospital associations recommended that we not make any change to the labor-related share calculation, while proceeding with market basket rebasing, until completing a more thorough examination of the proportion of labor costs influenced by the local labor market, noting that we included in our methodology costs related to, influenced by, or that vary with the local labor market, even if these services may be purchased at the national level.

MedPAC commented that it believes that certain expenditures identified in our methodology as locally purchased are in fact purchased, in whole or in part, in national markets. The Commission gave examples such as computing, legal, and accounting services. The Commission noted it has worked with us in the past to discuss these issues, and commented that continued use of our proposed approach is appropriate in the absence of a superior method. Several commenters referred to the difference between MedPAC's and CMS's methodologies and suggested that we should adopt MedPAC's methodology.

Other commenters argued the labor-related share must be decreased, noting that increasing the percentage will only exacerbate current flaws in the payment system. Some commenters referred to the fact that the outpatient prospective payment system labor-related share is only 60 percent. Another commenter suggested the labor-related share should be changed to a State-specific share.

Still other commenters, some of whom represent national and State hospital associations, supported the proposed methodology, and expressed their belief that any revised methodology from the one discussed in the proposed rule would need to be separately proposed with an opportunity for specific public comment. It was also noted that it has been our standard practice to empirically estimate the labor share in accordance with changes in the market basket, and it was recommended that we continue to follow our empirical estimate. Another commenter stated that our proposed methodology is consistent with both our past practice and statutory mandate.

Response: We have decided not to proceed with reestimating the labor-related share at this time. We will conduct further analysis to determine the most appropriate methodology before proceeding. Therefore, for FY 2003, the labor-related share applicable to the standardized amounts will remain at 71.066 percent. Any future revisions to the labor-related share or the methodology will be proposed and subject to public comment.

We appreciate the input from commenters on this issue, and look forward to continuing to work with MedPAC and the hospital industry on future refinements to the labor-related share methodology.

Comment: One commenter offered several specific refinements to the proposed methodology. The commenter agreed with our proposal to remove postage costs from the methodology and recommended that insurance costs and certain other wage-related costs also be removed.

Another commenter noted that we are adjusting the labor portion of the standardized amount using data that is not measured through the existing hospital wage index. The commenter reports estimating a labor share of 61.656 percent by excluding contract labor costs not included in the wage index.

Response: As noted above, we are not revising our estimate of the labor-related share at this time. We will take these comments into consideration in our future analysis.

5. Separate Market Basket for Hospitals and Hospital Units Excluded From the Acute Care Hospital Inpatient Prospective Payment System

In its March 1, 1990 report, ProPAC recommended that we establish a separate market basket for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system. Effective with FY 1991, we adopted ProPAC's recommendation to implement separate market baskets. (See the September 4, 1990 final rule (55 FR 36049).) Prospective payment system hospitals and excluded hospitals and units tend to have different case mixes, practice patterns, and composition of inputs. The fact that excluded hospitals are not included under the acute care hospital inpatient prospective payment system in part reflects these differences. Studies completed by HCFA (now CMS), ProPAC, and the hospital industry have documented different weights for excluded hospitals and units and prospective payment system hospitals.

The excluded hospital market basket is a composite set of weights for Medicare-participating psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. We use cost report data for excluded freestanding hospitals whose Medicare average length of stay is within 15 percent (that is, 15 percent higher or lower) of the total facility average length of stay for excluded hospitals, except psychiatric hospitals. A tighter measure of Medicare length of stay within 8 percent (that is, 8 percent higher or lower) of the total facility average length of stay is used for freestanding psychiatric hospitals. This is done because psychiatric hospitals have a relatively small proportion of costs from Medicare and a relatively small share of Medicare psychiatric cases. While the 15-percent length of stay edit was used for the FY 1992-based index, the tighter 8-percent edit for psychiatric hospitals was not. We believe that limiting our sample to hospitals with a Medicare average length of stay within a comparable range to the total facility average length of stay provides a more accurate reflection of the structure of costs for treating Medicare patients.

Table 6 compares major weights in the rebased FY 1997 market basket for excluded hospitals with weights in the rebased FY 1997 market basket for acute care prospective payment system hospitals. Wages and salaries are 51.998 percent of total operating costs for excluded hospitals compared to 50.686 percent for acute care prospective payment hospitals. Employee benefits are 11.253 percent for excluded hospitals compared to 10.970 percent for acute care prospective payment hospitals. As a result, compensation costs (wages and salaries plus employee benefits) for excluded hospitals are 63.251 percent of costs compared to 61.656 percent for acute care prospective payment hospitals, reflecting the more labor-intensive services conducted in excluded hospitals.

A significant difference in the category weights also occurs in pharmaceuticals. Pharmaceuticals represent 5.416 percent of costs for acute care prospective payment hospitals and 6.940 percent for excluded hospitals. The weight for the excluded hospital market basket was derived using the same data sources and methods as for the acute care prospective payment market basket which were outlined previously. Differences in weights between the excluded hospital and acute care prospective payment hospital market baskets do not necessarily lead to significant differences in the rate of price growth for the two market baskets. If individual wages and prices move at approximately the same annual rate, both market baskets may have about the same overall price growth, even though the weights may differ substantially, because both market baskets use the same wage and price proxies. Also, offsetting price increases for various cost components can result in similar composite price growth in both market baskets.

TABLE 6.—FY 1997-BASED EXCLUDED HOSPITAL AND PROSPECTIVE PAYMENT SYSTEM HOSPITAL MARKET BASKETS, COMPARISON OF SIGNIFICANT WEIGHTS

Category	Rebased FY 1997-based excluded hospital market basket	Rebased FY 1997-based prospective payment system hospital market basket
Wages and Salaries	51.998	50.686
Employee Benefits	11.253	10.970
Professional Fees	4.859	5.401
Pharmaceuticals	6.940	5.416
All Other	24.950	25.527
Total	100.000	100.000

Table 7 lists the cost categories, weights, and proxies for the FY 1997-based excluded hospital market basket. For comparison, the FY 1992-based cost category weights are included. The proxies are the same as those used in the FY 1997-based acute care hospital inpatient prospective payment system market basket.

TABLE 7.—FY 1992-BASED AND FY 1997-BASED EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS AND PRICE PROXIES

Expense categories	Rebased FY 1997-based excluded hospital market basket weights	FY 1992-based excluded hospital market weights	FY 1997-based price proxy
1. Compensation	63.251	63.721	
A. Wages and Salaries	51.998	52.152	ECI-Wages and Salaries, Civilian Hospital Workers
B. Employee Benefits	11.253	11.569	ECI-Benefits, Civilian Hospital Workers
2. Professional Fees	4.859	2.098	ECI-Compensation for Professional, Specialty & Technical
3. Utilities	1.296	1.675	
A. Fuel, Oil, and Gasoline	0.272	0.401	PPI Commercial Natural Gas
B. Electricity	0.798	1.007	PPI Commercial Electric Power
C. Water and Sewerage	0.226	0.267	CPI–U Water & Sewerage Maintenance
4. Professional Liability Insurance	0.805	1.081	CMS Professional Liability Insurance Premiums Index
5. All Other	29.790	31.425	
A. All Other Products	19.680	24.227	
(1.) Pharmaceuticals	6.940	3.070	PPI Ethical (Prescription) Drugs
(2.) Direct Purchase Food	1.233	2.370	PPI Processed Foods and Feeds
(3.) Contract Service Food	1.146	1.098	CPI–U Food Away From Home
(4.) Chemicals	2.343	3.754	PPI Industrial Chemicals
(5.) Blood and Blood Products	0.821	N/A	PPI Blood and Blood Derivatives, Human Use
(6.) Medical Instruments	1.972	3.154	PPI Medical Instruments & Equipment
(7.) Photographic Supplies	0.184	0.400	PPI Photographic Supplies
(8.) Rubber and Plastics	1.501	4.865	PPI Rubber & Plastic Products
(9.) Paper Products	1.219	2.182	PPI Converted Paper & Paperboard Products
(10.) Apparel	0.525	0.890	PPI Apparel
(11.) Machinery and Equipment	0.936	0.212	PPI Machinery & Equipment
(12.) Miscellaneous Products	0.860	2.232	PPI Finished Goods less Food and Energy
B. All Other Services	10.110	7.198	
(1.) Telephone Services	0.382	0.631	CPI–U Telephone Services
(2.) Postage	0.771	0.295	CPI–U Postage
(3.) All Other: Labor Intensive	4.892	5.439	ECI-Compensation for Private Service Occupations
(4.) All Other: Non-Labor Intensive.	4.065	0.833	CPI–U All Items
Total	100.000	100.000	

Note: Due to rounding, weights may not sum to total.

Table 8 shows the historical and forecasted updates under both the FY 1997-based and the FY 1992-based excluded hospital market baskets.

TABLE 8.—FY 1992-BASED AND FY 1997-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004

Fiscal year (FY)	Rebased FY 1997-based excluded hospital market basket	FY 1992-based excluded hospital market basket
Historical Data:		
FY 1995	2.7	3.2
FY 1996	2.4	2.5
FY 1997	1.7	2.0
FY 1998	3.0	2.7
FY 1999	2.9	2.4
FY 2000	3.3	3.6
FY 2001	4.3	4.1
Average FYs 1995–2001	2.9	2.9
Forecast:		
FY 2002	4.0	3.0
FY 2003	3.5	3.2
FY 2004	3.1	3.2
Average FYs 2002–2004	3.5	3.1

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TLO502.SIM.

A comparison of the FY 1997-based index incorporating the new wage and benefits proxies (ECIs) and updated occupational wage proxies is included in Table 9. Like the FY 1997-based prospective payment hospital index showed, there is little difference in the index over time when different compensation proxies are used.

TABLE 9.—FY 1997-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004

Fiscal year (FY)	Rebased FY 1997-based excluded hospital market basket	
	Using ECIs for hospital wage and benefit	Using occupational wages and Benefits proxies
Historical Data:		
FY 1995	2.7	2.9
FY 1996	2.4	2.5
FY 1997	1.7	2.2
FY 1998	3.0	3.5
FY 1999	2.9	3.0
FY 2000	3.3	3.5
FY 2001	4.3	4.1
Average FYs 1995–2001	2.9	3.1
Forecast:		
FY 2002	4.0	3.4
FY 2003	3.5	3.3
FY 2004	3.1	3.3
Average FYs 2002–2004	3.5	3.3

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM

B. Capital Input Price Index

The Capital Input Price Index (CIPI) was originally detailed in the September 1, 1992 **Federal Register** (57 FR 40016). There have been subsequent discussions of the CIPI presented in the May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), and August 30, 1996 (61 FR 46196) rules in the **Federal Register**. The August 30, 1996 rule discussed the most recent revision and rebasing of the CIPI to a FY 1992 base year, which reflects the capital cost structure facing hospitals in that year.

We are revising and rebasing the CIPI to a FY 1997 base year to reflect a more recent structure of capital costs. To do this, we reviewed hospital expenditure data for the capital cost categories of depreciation, interest, and other capital expenses. As with the FY 1992-based index, we have developed two sets of weights in order to calculate the FY 1997-based CIPI. The first set of weights identifies the proportion of hospital capital expenditures attributable to each capital expenditure category, while the second is a set of relative vintage weights for depreciation and interest. The set of vintage weights is used to identify the proportion of capital expenditures within a cost category that

is attributable to each year over the useful life of capital assets in that category. A more thorough discussion of vintage weights is provided later in this section.

Both sets of weights are developed using the best data sources available. In reviewing source data, we determined that the Medicare cost reports provided accurate data for all capital expenditure cost categories. We are using the FY 1997 Medicare cost reports for acute care prospective payment system hospitals, excluding expenses from hospital-based subproviders, to determine weights for all three cost categories: Depreciation, interest, and other capital expenses. We compared the weights determined from the Medicare cost reports to other data sources for 1997, specifically the Bureau of the Census' BES and the AHA Annual Survey, and found the weights to be consistent with those data sources.

Lease expenses are not a separate cost category in the CIPI, but are distributed among the cost categories of depreciation, interest, and other, reflecting the assumption that the underlying cost structure of leases is similar to capital costs in general. We assumed 10 percent of lease expenses are overhead and assigned them to the other capital expenses cost category as overhead, as was done in previous capital market baskets. The remaining 90 percent of lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses.

Depreciation contains two subcategories: Building and fixed equipment and movable equipment. The split between building and fixed equipment and movable equipment was determined using the Medicare cost reports. This methodology was also used to compute the FY 1992-based index.

Table 10 presents a comparison of the rebased FY 1997 capital cost weights and the FY 1992 capital cost weights.

TABLE 10.—COMPARISON OF FY 1992 AND REBASED FY 1997 COST CATEGORY WEIGHTS

Expense categories	FY 1992 weights	Rebased FY 1997 weights	Price proxy
Total	1.0000	1.0000	
Total depreciation	0.6484	0.7135	
Building and Fixed Equipment Depreciation	0.3009	0.3422	Boeckh Institutional Construction Index—vintage weighted (23 years)
Movable Equipment Depreciation	0.3475	0.3713	PPI for machinery and equipment—vintage weighted (11 years)
Total interest	0.3184	0.2346	
Government/Nonprofit Interest	0.2706	0.1994	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)—vintage weighted (23 years)
For-profit Interest	0.0478	0.0352	Average yield on Moody's Aaa bonds—vintage weighted (23 years)
Other	0.0332	0.0519	CPI—Residential Rent

Because capital is acquired and paid for over time, capital expenses in any given year are determined by past and present purchases of physical and financial capital. The vintage-weighted CIPI is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the purchase patterns of building and fixed equipment and movable equipment over time. Because depreciation and interest expenses are determined by the amount of past and current capital purchases, we used the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the CIPI. Capital costs are inherently complicated and are determined by complex capital purchasing decisions over time, based on such factors as interest rates and debt financing. Capital is depreciated over time instead of being consumed in the same period it is purchased. The CIPI accurately reflects the annual price changes associated with capital costs, and is a useful simplification of the actual capital accumulation process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes. These unstable annual price changes do not reflect the actual annual price changes for Medicare capital-related costs. CMS's CIPI reflects the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we used a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. While the AHA Panel Survey provided a consistent database back to 1963, it did not provide annual capital purchases. The AHA Panel Survey did provide time series of depreciation and interest expenses that could be used to infer capital purchases over time. Although the AHA Panel Survey was discontinued after September 1997, we were able to use all of the available historical data from this survey since our base year is FY 1997.

In order to estimate capital purchases from AHA data for depreciation and interest expenses, the expected life for each cost category (building and fixed equipment, movable equipment, debt instruments) is needed. The expected life is used in the calculation of vintage weights. We used FY 1997 Medicare cost reports to determine the expected life of building and fixed equipment and movable equipment. The expected life of any piece of equipment can be determined by dividing the value of the fixed asset (excluding fully-depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 1997 cost reports, we determined the expected life of building and fixed equipment to be 23 years, and the expected life of movable equipment to be 11 years. By comparison, the FY 1992-based index showed that the expected life for

building and fixed equipment was 22 years, while that for movable equipment was 10 years. Our analysis of data for FYs 1996, 1998, and 1999 indicates very little change in these measures over time.

We used the fixed and movable weights derived from the FY 1997 Medicare cost reports to separate the AHA Panel Survey depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation. By multiplying the annual depreciation amounts by the expected life calculations from the FY 1997 Medicare cost reports, we determined year-end asset costs for building and fixed equipment and movable equipment. We subtracted the previous year asset costs from the current year asset costs and estimated annual purchases of building and fixed equipment and movable equipment back to 1963. From this capital purchase time series, we were able to calculate the vintage weights for building and fixed equipment, movable equipment, and debt instruments. Each of these sets of vintage weights is explained in detail below.

For building and fixed equipment vintage weights, we used the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh institutional construction index. Because building and fixed equipment has an expected life of 23 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 23-year periods.

Vintage weights for each 23-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period, and for each of the twelve 23-year periods from 1963 to 1997. The average of the twelve 23-year periods is used to determine the 1997 average building and fixed equipment vintage weights.

For movable equipment vintage weights, we used the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amount by the movable equipment price proxy, the PPI for machinery and equipment. Because movable equipment has an expected life of 11 years, the vintage weights for movable equipment are deemed to represent the average purchase pattern of movable equipment over 11-year periods.

Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation is done for each year in the 11-year period, and for each of the twenty-four 11-year periods from 1963 to 1997. The average of the twenty-four 11-year periods is used to determine the FY 1997 average movable equipment vintage weights.

For interest vintage weights, we used the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel Survey. Nominal annual purchase amounts were used to capture the value of the debt instrument. Because debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods.

Vintage weights for each 23-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period and for each of the twelve 23-year periods from 1963 to 1997. The average of the twelve 23-year periods is used to determine the FY 1997 average interest vintage weights. The vintage weights for the FY 1992 CIPI and the FY 1997 CIPI are presented in Table 11.

TABLE 11.—1992-BASED AND 1997-BASED VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year (From farthest to most recent)	Building and fixed equipment		Movable equipment		Interest	
	FY 1992 22 years	FY 1997 23 years	FY 1992 10 years	FY 1997 11 years	FY 1992 22 years	FY 1997 23 years
1	0.019	0.018	0.069	0.063	0.007	0.007
2	0.020	0.021	0.075	0.068	0.008	0.009
3	0.023	0.023	0.083	0.074	0.010	0.011
4	0.026	0.025	0.091	0.080	0.012	0.012
5	0.028	0.026	0.097	0.085	0.014	0.014
6	0.030	0.028	0.103	0.091	0.016	0.016
7	0.031	0.030	0.109	0.096	0.018	0.019
8	0.032	0.032	0.115	0.101	0.021	0.022
9	0.036	0.035	0.124	0.108	0.024	0.026
10	0.039	0.039	0.133	0.114	0.029	0.030
11	0.043	0.042	—	0.119	0.035	0.035
12	0.047	0.044	—	—	0.041	0.039
13	0.050	0.047	—	—	0.047	0.045
14	0.052	0.049	—	—	0.052	0.049
15	0.055	0.051	—	—	0.059	0.053
16	0.059	0.053	—	—	0.067	0.059
17	0.062	0.057	—	—	0.074	0.065
18	0.065	0.060	—	—	0.081	0.072
19	0.067	0.062	—	—	0.088	0.077
20	0.069	0.063	—	—	0.093	0.081
21	0.072	0.065	—	—	0.099	0.085
22	0.073	0.064	—	—	0.103	0.087

TABLE 11.—1992-BASED AND 1997-BASED VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES—Continued

Year (From farthest to most recent)	Building and fixed equipment		Movable equipment		Interest	
	FY 1992 22 years	FY 1997 23 years	FY 1992 10 years	FY 1997 11 years	FY 1992 22 years	FY 1997 23 years
23	.....	0.065	—	.....	—	0.090
Total	1.000	1.000	1.000	1.000	1.000	1.000

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate of increase for each expenditure category. Our price proxies for the FY 1997-based CIPI are the same as those for the FY 1992-based CIPI. We still believe these are the most appropriate proxies for hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability. We ran the FY 1997-based index using the Moody's Aaa bonds average yield and using the Moody's Baa bonds average yield as proxy for the for-profit interest cost category. There was no difference in the two sets of index percent changes either historically or forecasted. A more detailed explanation of our rationale for selecting the price proxies is in the August 30, 1996 final rule (61 FR 46196). The proxies are presented in Table 10.

Global Insights, Inc., DRIWEFA forecasts a 0.7 percent increase in the rebased FY 1997 CIPI for FY 2003, as shown in Table 12.

TABLE 12.—FY 1992 AND FY 1997-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, 1995–2004

Federal fiscal year	CIPI, FY 1992-based	CIPI, FY 1997-based
1995	1.2	1.5
1996	1.0	1.3
1997	0.9	1.2
1998	0.7	0.9
1999	0.7	0.9
2000	0.9	1.1
2001	0.6	0.9
Average: FYs 1995–2001	0.9	1.1
Forecast:		
2002	0.6	0.8
2003	0.5	0.7
2004	0.6	0.8

TABLE 12.—FY 1992 AND FY 1997-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, 1995–2004—Continued

Federal fiscal year	CIPI, FY 1992-based	CIPI, FY 1997-based
Average: FYs 2002–2004	0.6	0.8

Source: Global Insights, Inc, DRI–WEFA, 2nd[t] Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM.

This 0.7 percent increase is the result of a 1.3 percent increase in projected vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices, partially offset by a 2.3 percent decrease in vintage-weighted interest rates in FY 2003, as indicated in Table 13.

TABLE 13.—CMS CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1995–2005

Fiscal Year	Total	Total depreciation	Depreciation, building and fixed equipment	Depreciation, movable equipment	Interest	Other
Weights FY 1997	1.000	0.7135	0.3422	0.3713	0.2346	0.0519
Vintage-Weighted Price Changes						
1995	1.5	2.7	4.0	1.6	−1.8	2.5
1996	1.3	2.5	3.8	1.4	−2.3	2.6
1997	1.2	2.3	3.6	1.2	−2.4	2.8
1998	0.9	2.1	3.3	0.9	−3.0	3.2
1999	0.9	1.9	3.2	0.7	−2.8	3.2
2000	1.1	1.7	3.1	0.4	−1.6	3.4
2001	0.9	1.5	2.9	0.1	−2.2	4.3
Forecast						
2002	0.8	1.4	2.8	0.0	−2.2	4.3
2003	0.7	1.3	2.7	−0.1	−2.3	3.0
2004	0.8	1.3	2.6	−0.1	−2.0	2.8
2005	0.7	1.3	2.4	−0.1	−2.1	2.8

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM.

Rebasing the CIPI from FY 1992 to FY 1997 increased the percentage change in the FY 2003 forecast by 0.2 percentage points, from 0.5 to 0.7 as shown in Table 12. The difference is caused mostly by changes in cost category weights, particularly the smaller weight for interest and larger weight for depreciation. Because the interest component has a negative price change associated with it for FY 2003, the smaller share it accounts for in the FY 1997-based index means it has less of an impact than in the FY 1992-based index. The changes in the expected life and

vintage weights have only a minor impact on the overall percent change in the index. We did not receive any public comments on the rebasing and revising of the capital input price index.

V. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating Costs and Graduate Medical Education Costs

A. Transfer Payment Policy

1. Expanding the Postacute Care Transfer Policy to Additional DRGs (§ 412.4)

Existing regulations at § 412.4(a) define discharges under the acute care hospital inpatient prospective payment system as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Under section 1886(d)(5)(J) of the Act, which was added by section 4407 of Public Law 105–33, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary, to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section requires the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

In the July 31, 1998 final rule (63 FR 40975 through 40976), we specified the appropriate time period during which we would consider a discharge to postacute home health services to constitute a transfer as within 3 days after the date of discharge. Also, in the July 31, 1998 final rule, we did not include in the definition of postacute care transfer cases patients transferred to a swing-bed for skilled nursing care (63 FR 40977).

The Conference Agreement that accompanied Public Law 105–33 noted that ''(t)he Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a postacute care setting after a very short acute care hospital stay. The conferees believe that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' (H.R. Report No. 105–217, 105th Cong., 1st Sess., 740 (1997).)

In the July 31, 1998 final rule (63 FR 40975), we implemented section 1886(d)(5)(J) of the Act, which directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified the following DRGs to be subject to the special 10 DRG transfer rule:

- DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack);
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe);
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity);
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age >17 with CC);
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age >17 without CC);
- DRG 236 (Fractures of Hip and Pelvis);
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC);
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC);
- DRG 429 (Organic Disturbances and Mental Retardation); and
- DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses).

Similar to our existing policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer for 7 of the 10 DRGs receives twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer, up to the full DRG payment. However, 3 of the 10 DRGs exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these 3 DRGs, hospitals receive 50 percent of the full DRG payment plus the per diem for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment. This is consistent with section 1886(d)(5)(J)(i) of the Act, which recognizes that in some cases ''a substantial portion of the costs of care are incurred in the early days of the inpatient stay.''

The statute provides that, after FY 2000, the Secretary is authorized to expand this policy to additional DRGs. In July 1999, the previous Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, CMS did not propose any change to the postacute care settings or the 10 DRGs in FY 2001 or FY 2002.

Under contract with CMS (Contract No. 500–95–0006), Health Economics Research, Inc. (HER) conducted an analysis of the impact on hospitals and hospital payments of the current postacute care transfer provision. We included in the August 1, 2000 final rule (65 FR 47079) a summary of that analysis. Among other issues, the analysis sought to evaluate the reasonableness of expanding the transfer payment policy beyond the current 10 selected DRGs.

The analysis supported the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent

choices based on the other criteria as well. Most have fairly high short-stay PAC rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

The HER report discussed the issues related to potential expansion of the postacute care transfer policy to all DRGs. In favor of this expansion, HER pointed to the following benefits:

- A simple, uniform, formula-driven policy;
- The same policy rationale exists for all DRGs;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Eliminate disparities between hospitals that happen to be disproportionately treating the current 10 DRGs and hospitals with an aggressive, short-stay, postacute care transfer policy for other DRGs.

The complete HER report may be obtained at: *http://www.cms.hhs.gov/medicare/ippsmain.asp.*

In the May 9, 2002 proposed rule, we stated that, consistent with HER's findings, we believed expanding the postacute care transfer policy to all DRGs might be the most equitable approach, since a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals, depending on the types of cases treated. For example, a hospital specializing in some of the types of cases included in the current 10 DRG transfer policy would receive reduced payments for those cases transferred for postacute care after a brief acute inpatient stay, while a hospital specializing in cases not included in the current 10 DRGs could be just as aggressive in transferring its patients for postacute care, but it would receive full payment for those cases.

Another aspect of the issue is that some hospitals have fewer postacute care options available for their patients. In its June 2001 Report to Congress: Medicare in Rural America, MedPAC wrote: ''[a] shortage of ambulatory and post-acute care resources may prevent rural hospitals from discharging patients as early in the episode of care as urban hospitals would'' (page 68). MedPAC went on to note that the decline in length of stay for urban hospitals since 1989 was greater for hospitals than for rural hospitals (34 percent compared with 25 percent through 1999), presumably due to earlier discharges to postacute care settings. Although the MedPAC report contemplated returning money saved by expanding the policy to the base payment rate, thereby increasing payments for nontransfer cases, currently section 1886(d)(5)(I)(ii) of the Act provides that any expansion to the postacute care transfer policy would not be budget neutral. (Budget neutrality refers to adjusting the base payment rates to ensure total aggregate payments are the same after implementing a policy change as they were prior to the change.) Nevertheless, over the long run, reducing Medicare Trust Fund expenditures for patients who are transferred to a postacute care setting after a very short acute care hospital stay would improve the program's overall financial stability.

As noted in the proposed rule, we believe that the current policy may create payment inequities among patients and among hospitals. By expanding the postacute care transfer policy, we would expect to reduce or eliminate these possible inequities. Therefore, in the May 9, 2002 proposed rule, we announced two options that we might use to expand the postacute care transfer provision and solicited comments and additional methodologies from commenters. The first method we proposed was to expand the postacute care transfer provision to all DRGs. The second proposal was to expand the provision to an additional 13 DRGs (We selected 10 DRGs using the same methodology we used in the July 31, 1998 final rule. Three of these 10 additional DRGs were paired, making the total 13.). However, expanding the postacute care transfer policy in this limited manner would retain many of the potential inequities of the current system.

As discussed further in the specific comments and responses that follow, we are not expanding the discharge to postacute care provision to additional DRGs for FY 2003. We believe the commenters have raised many issues regarding the impact of expanding this policy that we need to consider carefully before proceeding. In particular, due to the limited time between the close of the comment period and the required publication date of August 1, we were unable to completely analyze and respond to all of the points that were raised. However, we will continue to conduct research to assess whether further expansion of this policy may be warranted for FY 2004 or subsequent years and, if so, how to design any such refinements.

Comment: Many commenters argued that, in a system based on averages, expansion of the postacute care transfer policy negatively influences, and in fact penalizes, hospitals for efficient care. They claimed that this policy indiscriminately penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place. They believed that the postacute care transfer provision creates a perverse incentive for hospitals to keep patients longer.

Commenters also stated their concern that the expansion of the transfer provision violates the fundamental principle of the Medicare DRG payment system. The system is based on payments that will, on average, be adequate. These commenters argued that expansion of the transfer policy would give the system a per-diem focus and would mean that hospitals would be paid less for shorter than average lengths of stay, although they would not be paid more for the cases that are longer than average (except for outlier cases). One commenter suggested that if we expand the transfer rule, we should adopt a policy to pay more for long-stay cases.

Response: The Conference Agreement accompanying Public Law 105–33 states that ''Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' The current postacute care transfer policy adjusts payments to hospitals to reflect the reduced length of stay arising from the shift of patient care from the acute care setting to the postacute care setting. In addition, because Medicare also often pays for the postacute care portion of beneficiaries' care, the transfer policy appropriately adjusts hospitals' payments to avoid duplicate payments for the care provided during a patient's episode of care.

However, we are not expanding the postacute care transfer policy in this final rule because we are not able to completely respond to all of the points raised by commenters prior to publication of the final rule. Specifically, we intend to undertake a more comprehensive analysis of the impact on the averaging aspects of the prospective payment system if this policy were to be expanded. We agree with the commenters that the transfer policy should not hamper the provision of effective patient care, and any future expansion will consider both the need to reduce payments to reflect cost-shifting due to reductions in length of stay attributable to early postacute care transfers and the need to ensure that payments, on average, remain adequate to ensure effective patient care.

Comment: Commenters believed that the proposal to expand the postacute care transfer policy would place an additional administrative burden on hospitals and would expand the liability of hospitals for decisions that are not in their control, particularly after the patient has gone home. In cases where an acute care hospital is unaware that a patient has been sent to a postacute care facility or is receiving home health care, the commenters argued that it should not be the burden of the hospital to obtain that information.

Response: As stated previously, we are not expanding the postacute care transfer policy at this time. In response to the point raised by the commenter, with respect to our current policy, in those cases where the hospital discharges a beneficiary to home and the beneficiary subsequently receives postacute care, without the hospital's knowledge, the incorrect discharge code will not be considered fraudulent. However, if the hospital has knowledge of the beneficiary receiving postacute care after discharge, the hospital is responsible for submitting the claim as a transfer or submitting an adjustment bill.

Comment: Some commenters noted that, although the statute clearly states that the Secretary is authorized to expand the postacute care transfer policy to additional DRGs, the Secretary is not required to do so. These commenters pointed to the policy decisions made in FY 2001 and FY 2002 not to expand the policy and encouraged CMS to make the same policy decision for this and all subsequent years, calling the proposed expansion unjustified and unreasonable.

Several commenters argued that, although the Secretary does have authority to expand the postacute care transfer provision, the Secretary was not given the authority to expand the provision to all DRGs. Section 1886(d)(5)(J)(iv) of the Act provides that the Secretary may extend the policy to additional DRGs with high volumes of discharges to postacute care settings. Commenters noted that not all DRGs meet this criteria.

Response: We agree that we are not required by section 1886(d)(5)(J)(iv) of the Act to expand the transfer provision beyond the 10 DRGs currently covered under the policy. However, the statute clearly indicates that the policy may be expanded further, as appropriate. Whether the policy should be expanded to all DRGs or a few will be considered in future analysis.

Comment: Several commenters believed that the impact of the expansion of the postacute care transfer needs to be considered more thoroughly and noted that the impact of such an expansion was not included in the proposed rule impact tables. These commenters were concerned that the overall effect of implementing either of the two proposed expansions would result in an overall decrease in per case payments in FY 2003. Commenters believed this expansion would disproportionately harm teaching hospitals that treat the most costly and complex cases within each DRG. They further charged that this policy would interfere with good clinical decisionmaking.

Response: We did not analyze the postacute care transfer policy in the impact tables in the proposed rule because we did not propose a specific policy expansion. We did include overall savings estimates attributable to the provision in the preamble discussion. The full impact of any proposed expansion of this policy, including the impacts on specific categories of hospitals, would be considered fully before proceeding to expand the policy in the future.

Comment: Many commenters strongly opposed the proposal to expand the postacute care transfer policy to all DRGs. Several commenters suggested that we repeal the original 10 DRG postacute care transfer policy provision, on the grounds that, through experience, hospitals have learned to operate more efficiently and seek best practices in patient care management. Therefore, the prospective payment system has met its objectives and lengths of stay have been reduced. In addition, the commenters noted that the lower length of stay achieved is better for patients due to lower risk of acquiring a nosocomial infection and better recovery rates at home. Therefore, the commenters argued, hospitals that have shortened the length of stay across all DRGs should not be punished by a reduction in payment amounts to per diem rates. As such, the commenters argued that premature discharges should be identified through the Quality Improvement Organization review process and not by the prospective payment system.

Response: We agree that shorter lengths of stay are better for patients in general and that more efficient hospitals should not be penalized for greater than average efficiency. In the July 31, 1998 final rule implementing the policy for the current 10 DRGs, we included analysis showing that, across virtually all lengths of stay for each of the 10 DRGs, Medicare paid in excess of costs even after the implementation of this provision. We also note that we do not believe the intent of this policy was to require a change in physician clinical decisionmaking, nor in the manner in which physicians and hospitals practice medicine. Rather, it simply addresses the appropriate level of payments once those decisions have been made, so the intent of the policy was to avoid overpayments. We agree with the commenter that an appropriate mechanism to identify premature discharges is the quality review process. As we have noted above, we will consider fully all of the financial implications on hospitals before proceeding to expand the policy in the future.

Comment: Some commenters stated that there is no longer any justification to expand the postacute care policy, particularly to all DRGs. Commenters argued that expansion is unjustified because at the time the original policy was implemented, data showed that lengths of stay were dropping and that use of postacute care was increasing. The commenters indicated that, since that time, inpatient length of stay has stabilized and Medicare spending on postacute care has slowed. In addition, any incentive hospitals may have had to discharge patients early to a postacute care facility has been removed now that Medicare also pays these facilities under prospective payment systems.

In addition, commenters stated that neither CMS nor its contractor, HER, has provided data to support the assumption that hospitals are benefiting financially from short-stay postacute care transfer cases. In fact, commenters noted that the HER report included one table that suggests the opposite is true. As described by the commenters, Table 4–8 in the HER report shows the average cost of short-stay cases in the 10 DRGs currently subject to the payment reduction. As shown by this table, short-stay postacute transfer cases are 7.4 percent more costly than short-stay nonpostacute care transfer cases. As a result, the commenters asserted that postacute care transfer cases are significantly less profitable than the non-postacute care transfer cases.

Response: While it is true that postacute care providers such as skilled nursing facilities, home health agencies, and rehabilitation hospitals are now paid under prospective payment systems rather than cost-based payment systems, the acute hospital still has an incentive to discharge patients as soon as possible. The impact of expanding prospective payments to other settings is that it changes the incentives for those providers in terms of their willingness to continue to accept patients needing a more acute level of

care, because sicker patients are more likely to have above average costs. There is no impact on the incentives of acute care hospitals.

We point out that the analysis prepared by HER was undertaken as an evaluation of the original policy, conducted in 2000 based on partial FY 1999 data. With respect to HER's finding that patients transferred for postacute care are more expensive than cases discharged home, one would expect cases receiving followup care to be sicker and require more resources. In fact, the postacute care transfer policy was implemented out of concern that these patients were being transferred out of the acute care setting much earlier in the course of their treatment than had previously been the case, and that some of the acute care portion of the patients' hospitalization was being provided by the postacute care facility. Because the acute care hospital was receiving the full DRG payment and the postacute care facility was receiving higher cost-based reimbursement, the Medicare program was paying, in essence, two facilities for the acute care of the patient.

Comment: Commenters noted that in the proposed rule CMS quoted five points from the HER report that supported an expansion of the provision, but did not include the section of the HER report that lists the arguments against expansion. The commenters included this list of HER's arguments against expansion:

- Expansion to all DRGs would require multiple per-diem payment policies. The current ten DRGs require two distinct payment methodologies to ensure equitable reimbursement. A policy covering all DRGs might require many more methodologies.
- The policy would be irrelevant for many DRGs. Many DRGs have few or no cases that are discharged to postacute care.
- Expansion to all DRGs would have relatively high costs compared to the benefits. There is little benefit to extending the policy to the many DRGs with low postacute care volume. The cost of requiring that fiscal intermediaries implement and audit compliance with the policy for these DRGs would dilute the overall benefit to the program.
- It would be difficult to identify unrelated postacute care cases prior to admission. If a patient is under postacute care before admission and then returns to that care after an unrelated admission, the transfer policy does not apply. With many more DRGs, CMS and hospitals would have more work sorting out the unrelated admissions.
- Many DRGs are ''inhomogeneous.'' HER cautioned that payment under the postacute care transfer policy would be inequitable for ''inhomogeneous DRGs'' that contain two or more distinct types of cases with disparate lengths of stay.

Response: The negative points raised above were included in our report of HER's analysis in the August 1, 2000 final rule (65 FR 47081). We note that in the final rule we also referred readers to where they could obtain a copy of the complete report.

Comment: Commenters analyzed the 13 DRGs identified in the proposed rule for possible partial expansion of the postacute care transfer policy using information derived from the FY 2000 MedPAR data. The commenters reported that many of the DRGs are inhomogeneous, including a wide variety of cases, some of which may be susceptible to early transfer and some of which may not.

Response: We are not adopting either of the methodologies for expanding the postacute care transfer policy at this time. However, if in the future we should consider expanding the policy, we will consider the effect of inhomogeneity in any DRGs we select.

Comment: Some commenters believed that the current system is inequitable. However, they argued that targeting 13 additional DRGs would only worsen the problem, and extending the policy to all DRGs is not an acceptable response. Commenters urged us to work to have the policy repealed altogether or at least to revise the policy to make it more equitable. For example, commenters noted that DRG 483 (Tracheostomy except for face, mouth and neck diagnoses), which is included under the current policy, has an average length of stay of 35 days. Commenters noted that the variation around the average is quite high, and that patients requiring this procedure and level of care almost always require postacute care. Therefore, commenters contended, because the variation around the average is so large, and the per diem cost for this DRG is well above average, the postacute care transfer policy has a very significant impact on payment that is unrelated to the use of postacute care services. These commenters urged us to reconsider the current policy because they believed that the logic of applying the standard per diem methodology to this DRG is flawed. They urged us either toreplace this DRG with another one on its high-volume postacute care transfer list or change the payment method to one that addressed the length of stay volatility.

Response: We believe the current policy remains an appropriate response to reductions in length of stay resulting from shifting care out of the acute hospital setting. However, as noted above, we do have concerns about limiting it to 10 specific DRGs. We will continue to closely monitor the data to assess whether future expansions or refinements are needed. With respect to the inclusion of DRG 483 in the current 10 DRGs covered by the postacute care transfer policy, in the July 31, 1998 final rule we responded to a similar comment (63 FR 40981). Our analysis showed this DRG was appropriate to include under the policy. Over 45 percent of discharges from this DRG were to postacute care, and it was ranked ninth in terms of volume of cases receiving postacute care. These factors qualify it for inclusion in the postacute care transfer policy under section 1886(d)(5)(J) of the Act.

Comment: One commenter contended that expanding the postacute care transfer provision would distort the meaning of a transfer case. According to the commenter, a transfer is a case that has been admitted to one hospital and is stabilized there, but which is then sent to another acute care hospital for treatment that the first hospital was not equipped to provide. The commenter further explained that patients discharged to postacute care, in contrast, have completed the acute care phase of their treatment and need postacute care either to assist their convalescence or to manage a chronic illness. The commenter contended that these are very different concepts.

Response: Under the acute inpatient prospective payment system, payments to the transferring hospital are reduced to reflect the fact that the patient is transferred prior to receiving the full course of treatment from the acute hospital. When Congress established the postacute care transfer policy, it did so in recognition of the fact that hospitals were transferring patients who still had acute symptoms into the postacute care setting for the remainder of their care. Therefore, the principle that the transferring hospital did not provide the full course of treatment is consistent under both the preexisting policy and the postacute care transfer policy.

Comment: One commenter claimed that the special payment formula for a transfer from DRG 209, 210 and 211 often results in less payment than the flat per diem method. The commenters provided an example assuming that a DRG with a payment of $10,000 and an average length of stay of 5 days received a per diem rate of $2,000. For a transfer case with a stay of 4 days under the

standard per diem transfer payment, the payment rate would be $10,000 ($4,000 for the first day and $2,000 for each of the next 3 days). The commenter argued that, under the special transfer payment policy, the payment rate would be only $8,000 ($5,000 for the first day and $1,000 for each of the next 3 days). The commenter recommended that we increase the percentage of the per diem paid on days after the first day to 75 percent of the per diem under the special payment method.

Response: Under § 412.4(f)(2), payment for a postacute care transfer case from DRGs 209, 210, or 211 is equal to 50 percent of the appropriate prospective payment rate for the first day of the stay, and 50 percent of the amount the hospital would receive under the standard transfer payment methodology. Thus, the example provided by the commenter is not correct. The payment would be the full $10,000 if the patient was transferred on the fourth day. Rather than receiving $5,000 for the first day, the hospital in the example would receive $7,000 (50 percent of the full DRG payment equals $5,000, plus 50 percent of the standard transfer payment equals $2,000, because the standard transfer payment is double the per diem for the first day of a transfer stay). The hospital would receive $1,000 for each of the next 3 days, resulting in total payments under this special transfer payment rule equal to $10,000 on day 4.

This example also demonstrates that, if the patient stay is one day shorter than average, the hospital receives the full DRG rate. Using both postacute care transfer payment methodologies, the hospital would receive the full DRG amount if the patient stay is one day shorter than the national average.

Comment: One commenter suggested that we determine if the administrative resources we are using to recalculate a hospital's payment under this policy are actually saving the Medicare program money or if a greater amount of administrative resources are spent to recover the payment differential for the transferred beneficiary. The commenter stated that we should not expand a ''cost-savings'' policy that fails to result in true savings.

Response: Currently, the transfer payment calculation is made at the time a claim is processed based on the discharge status code assigned by the hospital to the patient at the time of discharge. Therefore, there is no recalculation, and thus the administrative costs associated with this policy are marginal, as long as hospitals appropriately code the patient's discharge status.

Comment: Another commenter recommended that the postacute care transfer issue be addressed from a total system perspective, centered on meeting the patients' needs and include referral dynamics from the new postacute care prospective payment systems. The commenter also suggested that there should be an analysis of the medical versus payment dynamics of the 3-day prior hospitalization requirement for postacute care coverage.

One commenter suggested that we expand the postacute care transfer policy to include swing beds. The commenter pointed to the ease with which hospitals may move these swing beds from one care setting to another, suggesting that it would be easy for hospitals with swing beds to get around the existing transfer policy.

Response: We will take these suggestions into consideration as we continue to monitor the transfer policy. With respect to expanding the policy to include transfers to swing beds, we indicated in the July 31, 1998 final rule that we elected not to include swing beds under this policy because of the potential adverse impact on small rural hospitals. At this time, we are not changing this policy, although we will continue to evaluate whether it is appropriate to exclude transfers to swing beds from the postacute care transfer policy.

Comment: One commenter recommended waiting at least 3 years before expanding the transfer policy to provide for sufficient time for the entire continuum of care to reach equilibrium. In addition, the commenter indicated that when independent groups analyzed internal data on the 10 DRGs initially identified in the existing postacute care transfer policy, they found only 3 where there were significant numbers of transfers to postacute care. The commenter recommended reanalyzing the current policy to determine whether volume and disposition of the DRGs still require the policy. Some commenters stated that the perceived ''gaming'' hypothesis does not exist, meaning that hospitals are not cutting short patient care in order to make more money. Another commenter suggested that we monitor the recalibration of DRG weights, noting that if patients are being discharged too soon, these premature discharges would be reflected in frequent readmissions to the hospital, would increase the acuity of postacute care providers, and would lower the charges for acute stays. Earlier discharges will ultimately result in lower weights for associated DRGs. The commenter indicated that we could then easily monitor readmissions and acuity of postacute care treatment to target problem providers.

Response: We will examine these and other issues in future analysis of this issue. With respect to the treatment of transfers in DRG recalibration, we note that a transfer case is counted as only a fraction of a case toward DRG recalibration based on the ratio of its transfer payment to the full DRG payment for nontransfer cases. This ensures the DRG weight calculation is consistent with the payment policy for these cases.

2. Technical Correction

When we revised our regulations on payments for discharges and transfers under § 412.4 in the July 31, 1998 final rule (63 FR 41003), we inadvertently excluded discharges from one hospital area or unit to another inpatient area or unit of the hospital that is paid under the acute care hospital inpatient prospective payment system (§ 412.4(b)(2)) in the types of cases paid under the general rule for transfer cases. In the May 9, 2002 proposed rule, we proposed to correct the regulation text to reflect our policy (as reflected in prior preamble language) that transfers from one area or unit within a hospital to another are not paid as transfers (except as described under the special 10 DRG rule at § 412.4(c)). We proposed to correct this error by revising § 412.4(f)(1) to provide that only the circumstances described in paragraphs (b)(1) and (c) of § 412.4 are paid as transfers under the general transfer rule.

We did not receive any public comments on this proposal. Therefore, we are adopting the proposed revisions of the regulations text as final. This correction reflects the fact that transfers under § 412.4(b)(2) are to be paid as discharges and not transfers.

B. Sole Community Hospitals (SCHs) (§§ 412.77 and 412.92)

1. Phase-In of FY 1996 Hospital-Specific Rates

Under the acute care hospital inpatient prospective payment system, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that

a hospital must meet to be classified as an SCH are located in § 412.92.

To be classified as an SCH, a hospital either must have been designated as an SCH prior to the beginning of the hospital inpatient prospective payment system on October 1, 1983, or must be located more than 35 miles from other like hospitals, or the hospital must be located in a rural area and meet one of the following requirements:

• It is located between 25 and 35 miles from other like hospitals, and it—

—Serves at least 75 percent of all inpatients, or at least 75 percent of Medicare beneficiary inpatients, within a 35-mile radius or, if larger, within its service area; or

—Has fewer than 50 beds and would qualify on the basis of serving at least 75 percent of its area s inpatients except that some patients seek specialized care unavailable at the hospital.

• It is located between 15 and 35 miles from other like hospitals, and because of local topography or extreme weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years.

• The travel time between the hospital and the nearest like hospital is at least 45 minutes because of distance, posted speed limits, and predictable weather conditions.

Effective with hospital cost reporting periods beginning on or after April 1, 1990, section 1886(d)(5)(D)(i) of the Act, as amended by section 6003(e) of Public Law 101–239, provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

• The Federal rate applicable to the hospital;

• The updated hospital-specific rate based on FY 1982 costs per discharge; or

• The updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113 added section 1886(b)(3)(I) to the Act, and section 213 of Public Law 106–554 made further amendments to that section of the Act extending to all SCHs the ability to rebase their hospital-specific rates using their FY 1996 operating costs, effective for cost reporting periods beginning on or after October 1, 2000. The provisions of section 1886(b)(3)(I) of the Act were addressed in the June 13, 2001 interim final rule with comment period (66 FR 32177) and were finalized in the August 1, 2001 final rule (66 FR 39872).

In the June 13, 2001 interim final rule, we correctly described the provisions of section 1886(b)(3)(I) of the Act, as amended, and their implementation. However, in the August 1, 2001 final rule, in summarizing the numerous legislative provisions that had affected payments to SCHs, we incorrectly described the application of the statutory provisions in the background section of the preamble on SCHs (66 FR 39872). (We wish to point out that the Addendum to the August 1, 2001 final rule accurately describes the calculation of the hospital-specific rate (66 FR 39944).) Specifically, the payment options that we described in the August 1, 2001 preamble language regarding SCHs were incorrect in that we did not include the Federal rate in the blends. Therefore, we are providing below a correct description of the provisions of section 1886(b)(3)(I) of the Act and clarifying their application in determining which payment options will yield the highest rate of payment for an SCH.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, the Federal rate is included in the blend, as set forth below:

• For discharges during FY 2001, 75 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates (identified in the statute as the subsection (d)(5)(D)(i) amount), plus 25 percent of the updated FY 1996 hospital-specific rate (identified in the statute as the ''rebased target amount'').

• For discharges during FY 2002, 50 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates, plus 50 percent of the updated FY 1996 hospital-specific rate.

• For discharges during FY 2003, 25 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates, plus 75 percent of the updated FY 1996 hospital-specific rate.

• For discharges during FY 2004 and subsequent fiscal years, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the disproportionate share hospital (DSH) adjustment, or the indirect medical education (IME) adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary makes a final adjustment at the close of the cost reporting period to determine precisely which of the payment rates would yield the highest payment to the hospital.

If a hospital disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in Subpart R of Part 405, which concern provider payment determinations and appeals.

The regulation text of § 412.77 and § 412.92(d) that was revised to incorporate the provisions of section 1886(b)(3)(I) of the Act, as amended, and published in the June 13, 2001 interim final rule with comment period (66 FR 32192 through 32193) and finalized in the August 1, 2001 final rule (66 FR 39932), is accurate.

We did not receive any comments on this clarification.

2. SCH Like Hospitals

Section 1886(d)(5)(D)(iii) of the Act provides that, to qualify as an SCH, a hospital must be more than 35 road miles from another hospital. In addition, there are several other conditions under which a hospital may qualify as an SCH, including if it is the ''* * * sole source of inpatient hospital services reasonably available to individuals in a geographic area * * *'' because of factors such as the ''* * * absence of other like hospitals * * *'' We have defined a ''like hospital'' in regulations as a hospital furnishing short-term, acute care (§ 412.92(c)(2)). Like hospitals refers to hospitals paid under the acute care hospital inpatient prospective payment system.

We have become aware that, in some cases, new specialty hospitals that offer a very limited range of services have opened within the service area of an SCH and may be threatening the special status of the SCH. For example, a hospital that offers only a select type of surgery on an inpatient basis would qualify under our existing rules as an SCH ''like hospital'' if it met the hospital conditions of participation and was otherwise eligible for payment under the acute care hospital inpatient prospective payment system. Under our existing regulations, an SCH could lose its special status due to the opening of such a specialty hospital, even though there is little, if any, overlap in the types

of services offered by the SCH and the specialty hospital.

We believe that limiting eligibility for SCH status to hospitals without SCH like hospitals in their service area is a way to identify those hospitals that truly are the sole source of short-term acute-care inpatient services in the community. A limited-service, specialty hospital, by definition, would not offer an alternate source of care in the community for most inpatient services and therefore, we believe, should not be considered a ''like'' hospital with the effect of negating SCH status of a hospital that is the sole source of short-term acute care inpatient services in the community. Therefore, in the May 9, 2002 proposed rule, we proposed to amend the definition of SCH like hospitals under § 412.92(c)(2), effective with cost reporting periods beginning on or after October 1, 2002, to exclude any hospital that provides no more than a very small percent of the services furnished by the SCH. We believe the percentage of overlapping services between the SCH and the limited service facility should be sufficiently small so that we can ensure that only hospitals that truly are the sole source of short-term acute care in their community qualify for SCH status. Therefore, we proposed that this percentage be set at 3 percent.

In the May 9, 2002 proposed rule, we solicited public comments on alternate appropriate levels of service overlap, as well as on the overall proposed change to the definition of like hospitals.

In response to comments as discussed below, we are adopting inpatient days as the unit of measurement for determining whether a hospital applying for SCH status can exclude from consideration as a like hospital another hospital within its service area (rather than services, as discussed in the proposed rule). The threshold would be set so that a hospital with total inpatient days of 8 percent or less compared to an SCH (or SCH applicant) would not be considered a like hospital for purposes of SCH designation.

We believe that Medicare inpatient days are a good proxy for service overlap. However, we will assess the impact of the overall change to the definition of like hospital and the service overlap proxy on SCHs and the prospective payment system. This assessment will determine whether refinements to this policy may be necessary in future years.

Comment: Many organizations commented on this proposal. Most supported it, but to varying degrees, because there is additional information they believe they need in order to better evaluate the proposal. The commenters noted definitions are needed for terms such as ''services'', ''overlap'', and ''provided services''. They also indicated that the data source (such as hospital cost reports or actual claims experience) and the methodology for measuring the services need to be defined and requested clarification of these issues in the final rule.

For example, commenters asked how CMS will measure overlap of services between the specialty hospital and the SCH (or SCH applicant). Would there be a weighting for volume or the volume capacity of the limited service specialty hospital? Would it be 3 percent of service lines (for example, obstetrics, cancer care, or cardiac services), or discharges, or DRGs reported?

Response: We appreciate the many helpful comments we received on this proposal. We proposed a 3-percent threshold of service overlap in an attempt to strike a balance between the need to ensure that SCHs do not lose their special status due to specialty hospitals opening nearby and the need to ensure that only hospitals that are the sole source of short-term acute hospital services for their community qualify as SCHs. We were concerned not to set the threshold too high because we wanted to ensure that only hospitals that truly are the sole source of care for their community continue to qualify as SCHs. Based on the comments we received, we are adopting alternative criteria, as described below. Adoption of this alternative criteria, comparing inpatient days, renders moot many of the questions raised by the commenters discussed above.

Comment: Some commenters pointed out that specialty hospitals take away profitable services that subsidizes other critical services such as emergency room service, intensive care unit services, skilled nursing care, and home health and hospice care furnished by the hospitals that typically qualify as SCHs.

These commenters believed SCH status was instituted to allow these types of providers the ability to provide access to a full range of services for Medicare patients, and that, as a result, these SCHs need to be protected.

One commenter requested that we require a hospital, to be considered a like hospital for purposes of SCH determinations, to provide, on an ongoing basis, all of the services typically furnished by an SCH, such as 24-hour emergency service and surgery and obstetrics services.

Some commenters recommended that the services provided by a limited-service specialty hospital should be defined so that, if the hospital had the capability of providing a service such as emergency service but was not staffed for 24-hour emergency service, was staffed only to the extent of referring its emergency patients to the SCH, or provided only its specialty-related emergency service, the hospital would not be considered to be furnishing emergency services, and, as a result, the hospital would not be considered a like hospital.

Other commenters did not believe that percentages of specific DRGs or a similar calculation of limited services would be a fair and equitable method of determining SCH status, particularly when considering whether a hospital with SCH status should be permitted to retain such status.

One commenter supported the proposal to amend the definition of SCH like hospitals to exclude any hospital that offers a very limited range of services. However, the commenter did not support the percent-of-services methodology. The commenter stated that the administrative burden associated with making this determination would be too great for both providers and intermediaries.

Response: Our proposal was intended to measure the extent of overlapping services because this would seem to be a useful indicator to determine whether another hospital in the community offers a plausible alternative to the SCH for residents in the area seeking inpatient acute care. For example, the existing regulations contemplate situations where hospitals with fewer than 50 beds may become eligible for SCH status despite the location of an otherwise like hospital within 35 miles, if the community hospital would admit at least 75 percent of the area residents who become inpatients were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital (§ 412.92(a)(1)(ii)).

Section 2810.B.3.d. of the Provider Reimbursement Manual contains instructions for excluding services not offered by the SCH applicant from the determination of whether the applicant admits at least 75 percent of the area residents who become inpatients. Under this process, the hospital obtains information as to the diagnoses of and services furnished to those residents or Medicare beneficiaries who obtained care outside the SCH applicant hospital's service area during the survey period.

In connection with the policy we proposed in the May 9, 2002 proposed

rule, we contemplated using a similar process to determine whether a limited-service specialty hospital should be excluded from the definition of like hospitals. However, we recognize that this process would be labor and data intensive. As a result, we were interested in evaluating the recommendations submitted by commenters.

Comment: Several commenters suggested using Medicare inpatient days in hospital units subject to the acute care hospital inpatient prospective payment system to identify whether a limited-service specialty hospital is likely to offer many of the services also offered by the SCH. Thus, for example, a specialty hospital that only provides orthopedic surgery with a 1-day recovery period would have its service weighted to reflect the limited intensity of such services.

Commenters believe that using Medicare inpatient days would allow easy administration by both CMS and its fiscal intermediaries, because these data are readily available in hospital cost reports. They believed that by considering only inpatient days in units subject to the acute care hospital inpatient prospective payment system, the focus would be limited only to those services germane to the general acute care needs of the Medicare community. Other commenters suggested using actual gross payments for Part A services to Medicare beneficiaries as the unit of measurement for services provided.

Response: We agree with the commenters who proposed using inpatient days as the comparative statistic to determine whether a limited-service specialty hospital may be excluded from the like hospital definition. Although DRGs provide a comparison that more closely reflects service overlap, we believe that we will attain a similar outcome, with less administrative complexity, by comparing inpatient days. Accordingly, we are adopting patient days attributable to units that provide a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system as the unit of measurement for determining whether a hospital applying for SCH status can exclude from consideration as a like hospital another hospital within its service area. The number of inpatient days is readily available from all participating hospitals because it is already captured on the cost report.

We believe that Medicare inpatient days are a good proxy for service overlap. However, we will assess the impact of the overall change to the definition of like hospital and the service overlap proxy on SCHs and the prospective payment system. This assessment will determine whether refinements to this policy may be necessary in future years.

Comment: The commenters were in agreement that the overlapping services threshold of 3 percent was too low and would not accomplish our intent of distinguishing specialty hospitals from full-service acute care hospitals. Alternative suggestions included overlapping services thresholds of 8 percent, 10 to 15 percent, and setting the threshold after evaluating actual data. One commenter stated that adopting less than a 10-percent overlap threshold would not protect existing SCHs from losing their special status as a result of a limited-service specialty hospital opening in their community.

Commenters offered the example where a heart hospital or other niche provider may perform inpatient services that represent closer to 10 or 15 percent of the services performed by SCHs. In this situation the SCH continues to remain the sole source of the full range of acute care services in the community, including essential emergency services, and thus deserves to retain SCH status. However, if the specialty hospital is considered a like hospital, it would jeopardize the special status of the SCH.

One commenter referred to the regulations, where, to qualify for SCH status, a hospital with another like hospital within 25 to 35 miles cannot have more than 25 percent of the admissions of residents within its service area admitted to other hospitals (§ 412.92(a)(1)(i)). The commenter suggested that, where the focus is on specialty hospitals that are not like hospitals, a threshold on the order of one-third of that 25-percent threshold would seem appropriate. The commenter suggests that a specialty hospital with only 8 percent service overlap with the community hospital would not be able to service the community's acute care needs.

Response: As stated above, based on our evaluation of the public comments and the situations, of which we are aware, where an existing SCH's special status is being threatened by a nearby limited-service specialty hospital, we believe the best approach would be to revise our proposed definition of like hospital for SCH purposes to exclude any hospital where the inpatient services overlap compared to the SCH (or the SCH applicant) is less than 8 percent, as measured by inpatient days.

The inpatient services would be measured by total inpatient days as reported on the hospitals' cost report, and should include all days attributable to units that provide a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system. We believe setting the threshold at 8 percent would distinguish the specialty hospitals, which have very limited inpatient use and, therefore, limited inpatient days, from general, acute care hospitals typical of SCHs. Therefore, we are revising proposed § 412.92 (c)(2) to reflect this change.

To determine whether a hospital qualifies as an SCH, the fiscal intermediary would make a determination whether a nearby hospital paid under the acute care hospital inpatient prospective payment system is a like hospital by comparing the total acute inpatient days of the SCH applicant hospital with the total acute inpatient days of the nearby hospital. If the total acute inpatient days of the nearby hospital is greater than 8 percent of the total inpatient days reported by the SCH applicant hospital, the hospital is considered a like hospital for purposes of evaluating the application for SCH status. If the total acute inpatient days of the nearby hospital is 8 percent or less of the total acute inpatient days of the applicant hospital, the nearby hospital is not considered a like hospital for purposes of evaluating the application for SCH status under § 412.92.

Comment: Some commenters questioned the effective date of the proposal because they see the definition revision as a clarification of existing legislation that should be treated as such, applying to all open matters, not prospectively only.

Response: This change is a revision to our current policy for defining like hospitals. Therefore, it is being implemented prospectively, starting with cost reporting periods that begin on or after October 1, 2002.

Current regulations establish that an approved SCH classification remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved (§ 412.92(b)(3)). It will be necessary, therefore, in situations where a SCH's eligibility is contingent on a nearby hospital being excluded from the like hospital comparison under this provision, for the fiscal intermediary to reevaluate periodically whether the exclusion is still appropriate, based on the most current inpatient days data.

In the event that a new, limited-service specialty hospital opens within the service area of an existing SCH, the

fiscal intermediary will monitor the number of patient days at the two hospitals to ensure that the specialty hospital does not exceed the 8 percent threshold.

Comment: Some commenters stated that, without understanding how the test actually would be conducted, what data would be used, and why a 3 percent threshold was selected, interested parties could not provide us with thoughtful, helpful comments. Accordingly, they recommended that we not finalize our proposal at this time. Instead, we should clarify our proposal and resolicit comments. In the interim, these commenters believed that we should grandfather SCH status for all existing SCHs while it further developing this policy. Similarly, several commenters suggested we further evaluate and develop this proposal and present it for public review and comment before finalizing the proposal.

One commenter stated that we should also consider adopting an altogether different approach. Rather than implement an objective, one-size-fits-all approach, we should instead develop review guidelines for our Regional Offices, and allow these Regional Offices to make case-by-case, fact-specific determinations using the guidelines. Such guidelines could, for example, utilize a quantitative evaluation, similar to what we proposed. In addition, Regional Offices could be directed to examine whether area beneficiaries have a choice in the area for general-acute care hospital services.

Response: We believe that, based on our understanding of the situations of which we are aware involving an SCH whose special status is being jeopardized by the opening of a limited-service specialty hospital in its service area, and similar situations described in the comments we received, an 8-percent threshold for the comparison of inpatient days as described above is appropriate. We are concerned that a case-by-case approach would result in inappropriate disparities across geographic areas in terms of how applications are reviewed.

C. Outlier Payments: Technical Change (§ 412.80)

Sections 1886(d)(5)(A) and (d)(5)(K) of the Act provide for payments, in addition to the basic prospective payments, for ''outlier'' cases; that is, cases involving extraordinarily high costs. Cases qualify for outlier payments by demonstrating costs that exceed a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME (§ 412.105) and DSH (§ 412.106) payments for the case and, for discharges on or after October 1, 2001, additional payments for new technologies or services.

Implementing regulations for outlier payments are located in subpart F of Part 412. Paragraph (a) of § 412.80 specifies the basic rules for making the additional outlier payments, broken down into three applicable effective periods. We have become aware that in paragraph (a)(2), which relates to outlier payments for discharges occurring on or after October 1, 1997, and before October 1, 2001, we did not include language to specify that the additional costs of outlier cases must exceed the standard DRG payment and any additional payment the hospital would receive for IME and for DSH, plus a fixed loss dollar threshold. Therefore, in the May 9, 2002 proposed rule, we proposed to make a technical change by revising § 412.80(a)(2), applicable for discharges occurring during the period between October 1, 1997 and October 1, 2001, to include the appropriate language regarding additional payments for IME and payments for DSH. (We note that when we amended § 412.80 to incorporate the provisions on the additional payments for new technology under paragraph (a)(3) (66 FR 46924, September 7, 2001), effective October 1, 2001, we did include this language.)

We did not receive any comments on this technical change.

D. Rural Referral Centers § 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts were the same for discharges beginning with that date, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

As discussed in Federal Register documents at 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be considered as a rural referral center for FY 1998 and later years so long as that hospital continues to be located in a rural area and does not voluntarily terminate its rural referral center status. Otherwise, a hospital seeking rural referral center status must satisfy applicable criteria.

Also, effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it was reinstated to rural referral center status (65 FR 47089).

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national mean case-mix index value for FY 2003 in the May 9, 2002 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2003 were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These values were based on discharges occurring during FY 2001 (October 1, 2000 through September 30, 2001) and include bills posted to CMS's records through December 2001.

In the May 9, 2002 proposed rule, we proposed that, in addition to meeting

other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have a case-mix index value for FY 2001 that is at least—

- 1.3229; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the May 9, 2002 proposed rule at 67 FR 31460).

Based on the latest data available (FY 2001 bills received through March 31, 2002), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have a case-mix index value for FY 2002 that is at least—

- 1.3225; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. The final median case-mix index values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2044
2. Middle Atlantic (PA, NJ, NY)	1.2247
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3014
4. East North Central (IL, IN, MI, OH, WI)	1.2345
5. East South Central (AL, KY, MS, TN)	1.2418
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1621
7. West South Central (AR, LA, OK, TX)	1.2595
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3162
9. Pacific (AK, CA, HI, OR, WA)	1.2785

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2001 (that is, October 1, 2000 through September 30, 2001). FY 2001 is the latest year for which we have complete discharge data available.

Therefore, in the May 9, 2002 proposed rule, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have as the number of discharges for its cost reporting period that began during FY 2001 a figure that is at least__

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the May 9, 2002 proposed rule at 67 FR 31460.)

Based on the latest discharge data available for FY 2001, the final median number of discharges for urban hospitals by census region areas are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,905
2. Middle Atlantic (PA, NJ, NY)	8,644
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	8,893
4. East North Central (IL, IN, MI, OH, WI)	7,890
5. East South Central (AL, KY, MS, TN)	6,953
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,696
7. West South Central (AR, LA, OK, TX)	6,226
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,167
9. Pacific (AK, CA, HI, OR, WA)	7,053

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2002, the hospital must have at least 3,000 discharges for its cost reporting period that began during FY 2001.

We did not receive any comments on the criteria for rural referral centers.

E. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment for a Medicare discharge to reflect the higher indirect operating costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the

IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as *r*, and a multiplier, which is represented as *c*, in the following equation: $c \times [(1 + r)^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio. Section 1886(d)(5)(B)(ii)(VII) of the Act provides that, for discharges occurring during FY 2003 and thereafter, the ''c'' variable, or formula multiplier, is 1.35. The formula multiplier of 1.35 represents a 5.5-percent increase in IME payment for every 10-percent increase in the resident-to-bed ratio.

2. Temporary Adjustments to the FTE Cap To Reflect Residents Affected by Residency Program Closure: Resident-to-Bed Ratio for Displaced Residents (§§ 412.105(a) and (f)(1)(ix))

In the August 1, 2001 hospital inpatient prospective payment system final rule (66 FR 39899), we expanded the policy at existing § 413.86(g)(8) (to be redesignated as § 413.86(g)(9)) which allows a temporary adjustment to a hospital's FTE cap when a hospital trains additional residents because of another hospital's closure, to also allow a temporary adjustment when a hospital trains residents displaced by the closure of another hospital's residency program (but the hospital itself remains open). We revised regulations at existing § 413.86(g)(8) to state that, if a hospital that closes a residency training program agrees to temporarily reduce its FTE cap, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the former hospital's residency training program. We defined ''closure of a hospital residency training program'' as when the hospital ceases to offer training for residents in a particular approved medical residency training program. The methodology for adjusting the caps for the ''receiving'' hospital and the ''hospital that closed its program'' as they apply to the IME adjustment and direct GME payments is set forth in the regulations at existing §§ 412.105(f)(1)(ix) and 413.86(g)(8)(iii), respectively.

In the final notice published in the **Federal Register** on August 1, 2001 rule, we noted a commenter who requested that CMS further revise the regulations to grant temporary relief to hospitals in calculating the IME adjustment with regard to application of the resident-to-bed ratio cap (66 FR 39900). The commenter believed that while the regulations provide for the cap on the number of residents to be temporarily adjusted, if the receiving hospital is not allowed to also adjust its resident-to-bed ratio in the prior year, the lower resident-to-bed ratio from the prior year could act to reduce the IME payments to the receiving hospital. The commenter suggested that, similar to the exception for residents in hospitals that begin new programs under § 412.105(a)(1), an adjustment should be made to the prior year's number of FTE residents, equal to the increase in the current year's FTEs that is attributable to the transferred residents. In response to the commenter, we stated that we had decided not to allow the exclusion of these displaced residents in applying the resident-to-bed ratio cap. We explained that, while we believed that the receiving hospital may be held to a lower cap in the first year of training the displaced residents, the receiving hospital would benefit from the higher cap in the subsequent years as the displaced residents complete their training and leave that hospital. However, we indicated that we would consider suggestions for possible future changes to this policy.

In the proposed regulation, we revisited this policy and explained that our rationale for not allowing the adjustment for displaced residents to the resident-to-bed ratio cap may have been faulty. We initially believed that, in the year following the last year in which displaced residents trained at the receiving hospital, the receiving hospital would benefit from the higher resident-to-bed ratio cap. However, we have determined that, while it is correct that the hospital will have a higher resident-to-bed ratio cap because of the higher number of displaced residents in the prior year, the receiving hospital's actual FTE count decreases as the displaced residents finish their training. Therefore, the receiving hospital would not need a higher resident-to-bed ratio in the prior year to accommodate the remaining FTEs. Consequently, the higher resident-to-bed ratio cap in fact would not benefit the receiving hospital. Thus, in the May 9, 2002 proposed rule, we proposed to allow the exclusion of residents displaced by either the closure of another hospital's program or another hospital's closure in applying the resident-to-bed ratio cap. Specifically, assuming a hospital is eligible to receive a temporary adjustment to its FTE cap as described in existing § 413.86(g)(8), we proposed that, solely for purposes of applying the resident-to-bed ratio cap in the *first* year in which the receiving hospital is training the displaced residents, the receiving hospital may adjust the numerator of the prior year's resident-to-bed ratio by the number of FTE residents that has caused the receiving hospital to exceed its FTE cap. (We note that, as we explain below in response to a comment, in this final rule we are revising the proposed language of § 412.105(a)(1)(iii) to state that the exception to the resident-to-bed ratio cap for closed hospitals and closed programs applies only through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced FTE residents. We further note that this adjustment to the resident-to-bed ratio cap does not apply to changes in bed size.) In the years subsequent to the first year in which the receiving hospital takes in the displaced residents, we believe an adjustment to the numerator of the prior year's resident-to-bed ratio is unnecessary because the receiving hospital's actual FTE count in those years would either stay the same or, as the displaced residents complete their training or leave that hospital, decrease each year. If all other variables remain constant, an increase in the current year's resident-to-bed ratio will establish a higher cap for the following year. In the second and subsequent years of training the displaced residents, the receiving hospital's resident-to-bed ratio for the current year would not be higher than the prior year's ratio and thus would not be limited by the resident-to-bed ratio cap.

In the cost reporting period following the departure of the last displaced residents, when the temporary FTE cap adjustment is no longer applicable, we proposed that, solely for purposes of applying the resident-to-bed ratio cap, the resident-to-bed ratio be calculated as if the displaced residents had not trained at the receiving hospital in the prior year. In other words, in the year that the hospital is no longer training displaced residents, the attendant FTEs should be removed from the numerator of the resident-to-bed ratio from the prior year (that is, the resident-to-bed ratio cap). We explained that because we proposed to allow the adjustment to the resident-to-bed ratio cap in the first year in which the receiving hospital trains displaced residents, it is equitable to remove those FTEs when calculating the resident-to-bed ratio cap after all the displaced residents have completed their training at the receiving hospital.

The following is an example of how the receiving hospital's IME resident-to-bed ratio cap would be adjusted for displaced residents coming from either a closed hospital or a closed program:

Example: Hospital A has a family practice program with 3 residents. On

June 30, 2002, Hospital A closes. Hospital B, which also has a family practice program, agrees to continue the training of Hospital A's residents beginning July 1, 2002. Its fiscal year end is June 30. As of July 1, 2002, the 3 residents displaced by the closure of Hospital A include 1 PGY1 resident, 1 PGY2 resident, and 1 PGY3 resident. In addition, Hospital B has 5 of its own residents, an IME FTE resident cap of 5, and 100 beds. Subject to the criteria under existing § 413.86(g)(8), Hospital B's FTE cap is temporarily increased to 8 FTEs. According to the proposed policy stated above, Hospital B's resident-to-bed ratio and resident-to-bed ratio cap would be determined as follows:

July 1, 2002 through June 30, 2003

• Resident-to-bed ratio: 5 FTEs + 3 displaced FTEs / 100 beds = .08 (line 3.18 of Worksheet E, Part A of the Medicare cost report, Form CMS 2552–96).

Note: For purposes of applying the rolling average calculation at § 412.105(f)(1)(v) to this example, it is assumed that Hospital B had 5 FTE residents in both the prior and the penultimate cost reporting periods. Therefore, 5 FTEs are used in the numerator of the resident-to-bed ratio. Under § 412.105(f)(1)(v), displaced residents are added to the receiving hospital's rolling average FTE count in each year that the displaced residents are training at the receiving hospital.)

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2002) + *3 displaced FTEs (from fiscal year end June 30, 2003)* / 100 beds = .08 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.08) or the resident-to-bed ratio cap from the prior year (.08) is used to calculate the IME adjustment. Therefore, Hospital B would use a resident-to-bed ratio of .08 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2003 through June 30, 2004

The PGY3 displaced resident has completed his or her family practice training on June 30, 2003 and has left Hospital B. Hospital B continues to train a displaced (now) PGY2 resident, and a displaced (now) PGY3 resident.

• Resident-to-bed ratio: 5 FTEs + 2 displaced FTEs / 100 beds = .07 (line 3.18 of Worksheet E, Part A of Form CMS 2552–96).

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2003) + 3 displaced FTEs (from fiscal year end June 30, 2003) / 100 beds = .08 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.07) or the resident-to-bed ratio cap from the prior year (.08) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .07 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2004 through June 30, 2005

Another of the remaining displaced residents has completed his or her family practice training on June 30, 2004 and has left Hospital B. Hospital B continues to train one displaced (now) PGY3 resident.

• Resident-to-bed ratio: 5 FTEs + 1 displaced FTE / 100 beds = .06 (line 3.18 of Worksheet E, Part A of Form CMS 2552–96).

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2004) + 2 displaced FTEs (from fiscal year end June 30, 2004) / 100 beds = .07 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.06) or the resident-to-bed ratio cap from the prior year (.07) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .06 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2005 through June 30, 2006

The last displaced resident has completed his or her family practice training on June 30, 2005 and has left Hospital B. Hospital B no longer trains any displaced residents, and, therefore, the last displaced resident is *removed* from the numerator of the resident-to-bed ratio cap.

• Resident-to-bed ratio: 5 FTEs + 0 displaced FTEs / 100 beds = .05

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2005) + *0 displaced FTEs (subtract 1 displaced FTE from FYE June 30, 2005)* / 100 beds = .05

• The lower of the resident-to-bed ratio from the current year (.05) or the resident-to-bed ratio cap from the prior year (.05) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .05.

We proposed that this exception to the resident-to-bed ratio cap for residents coming from a closed hospital or a closed program would be effective for cost reporting periods beginning on or after October 1, 2002, which was reflected in proposed revised § 412.105(a)(1).

Comment: Numerous commenters expressed support for our proposal to allow an adjustment to the resident-to-bed ratio cap for residents displaced by the closure of another teaching hospital or another hospital's GME program. One commenter added that, although the proposed adjustment to the resident-to-bed ratio in the first year would equitably reimburse hospitals who commence training the displaced residents at the beginning of their respective fiscal year, this adjustment would result in the receiving hospital being under-reimbursed in the first full year of residency training when a hospital or program closes toward the end of the receiving hospital's fiscal year. The commenter requested that CMS correct this inequity by extending the resident-to-bed ratio cap adjustment to include both the first partial and the first full year of training displaced residents at the receiving hospital.

Response: We agree with the commenter that our proposal to limit the adjustment to the resident-to-bed ratio cap to the first (cost reporting) year in which the receiving hospital is training the displaced residents may result in reduced payments to the receiving hospital if the receiving hospital begins training those residents at some point other than the beginning of a full fiscal year. Therefore, in this final rule, we are revising the language proposed under § 412.105(a)(1)(iii) to state that the exception to the resident-to-bed ratio cap for closed hospitals and closed programs applies through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced FTE residents. We note that the effective date of this revised policy is for cost reporting periods beginning on or after October 1, 2002.

For example, if receiving Hospital A has a fiscal year end (FYE) of December 31, 2003, and it begins training 3 displaced residents on November 1, 2003, for purposes of applying the resident-to-bed ratio cap, receiving Hospital A may add a 2 months' proportion of the 3 FTEs to the numerator of the resident-to-bed ratio cap from the prior cost reporting period (FYE December 31, 2002). Receiving Hospital A may also add the FTEs that continue training at the hospital during its cost reporting period ending December 31, 2004 to the numerator of the resident-to-bed ratio cap from the FY 2003 cost reporting period. However, no adjustment may be made for purposes of applying the resident-to-bed ratio cap for subsequent years. Other than the allowance for applying the resident-to-bed ratio cap adjustment through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced

residents, the policy is the same as that in the proposed rule.

Comment: One commenter commended CMS for realizing that it would be appropriate to allow eligible hospitals to receive a temporary adjustment to the application of the IME resident-to-bed ratio cap. However, the commenter believed that in lieu of the rationale that CMS utilized in drafting the regulation published on August 1, 2001 and to avoid penalizing eligible hospitals, CMS should apply a retroactive effective date of October 1, 2001 to this policy.

Response: We understand the commenter's concerns, and in proposing this policy, we acknowledged the need to allow for the temporary adjustment to the resident-to-bed ratio cap. However, because we do not have explicit statutory authority to do so, we are unable to apply this policy retroactively. Therefore, the effective date of this policy will be prospective; that is, for cost reporting periods beginning on or after October 1, 2002.

Comment: Some commenters asserted that the proposal requiring that the resident-to-bed ratio cap be calculated in the cost reporting period following the departure of the last displaced residents as if the displaced residents had not trained at the receiving hospital in the prior year, adds more complexity to an already burdensome IME calculation. The commenters stated that the number of residents likely to be involved with this provision is minimal, and accordingly, CMS should not finalize this provision.

Response: As we have explained in the proposed rule, we believe that in light of the addition of FTEs to the resident-to-bed ratio cap in the first full cost reporting period, it is equitable to remove those FTEs when calculating the resident-to-bed ratio cap in the year following the departure of the displaced residents. We disagree that requiring that the resident-to-bed ratio cap be calculated in the cost reporting period following the departure of the last displaced residents as if the displaced residents had not trained at the receiving hospital in the prior year is overly burdensome. It requires only a simple subtraction of FTEs from the numerator of the prior year ratio, and in the next issuance of the Medicare cost report instructions, we will be making a revision to the instructions for line 3.19 of Worksheet E, Part A of the cost report to reflect this policy.

Comment: One commenter was concerned about our proposal to adjust ''the numerator of the prior year's resident-to-bed ratio *by the number of FTE residents that has caused the receiving hospitals to exceed its FTE cap''* (emphasis added) (67 FR 31461, May 9, 2002). The commenter stated that, by describing the increase in the numerator in relation to the hospital's FTE cap, the intent of the provision will not be fulfilled unless the hospital is already at its FTE cap. The commenter explained that if, for example, Hospital A has 4 residents in both cost reporting years 2002 and 2003, has a FTE cap of 5 FTEs, and accepts 3 displaced residents in 2003, it exceeds the FTE cap by only 2 residents. Therefore, as proposed, the adjustment to the prior year resident-to-bed ratio would result in a ratio cap of 0.06 ((4+2)/100). The current year resident-to-bed ratio would be 0.07 ((4+3)/100). Since this exceeds the hospital's prior year resident-to-bed ratio, the resident-to-bed ratio for Hospital A will be held to 0.06. The commenter concluded that since our intent is not to penalize hospitals that accept displaced residents, the adjustment to the prior year resident-to-bed ratio must not rely on the FTE cap for a reference point, but rather, must equal the number of displaced residents.

Response: The original regulations concerning temporary adjustments for hospital closure were written in response to requests from hospitals for an exception to the FTE cap, to allow the additional residents coming from a closed hospital to be counted by the receiving hospital (63 FR 26329 and 26329, May 12, 1998). Similarly, in the July 30, 1999 final rule (64 FR 41522), we explained that we adopted this provision because hospitals had indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their FTE caps. Accordingly, the existing regulations discussing hospital and program closure at § 413.86(g)(8) (§ 412.105(f)(1)(ix) for IME) state that ''a hospital may receive a temporary adjustment to its FTE cap to reflect residents added'' because of the closure of another hospital or another hospital's program. Furthermore, existing §§ 413.86(g)(8)(ii)(B) and (g)(8)(iii)(A)(*2*) require that, in order for a hospital to receive this temporary FTE cap adjustment, the hospital must document ''that it is eligible for this temporary adjustment by identifying the residents who have * * * *caused the hospital to exceed its cap.* * * *'' (emphasis added). These regulations are only applicable in instances where the training of displaced residents causes a hospital to exceed its FTE cap; if a hospital has room under its FTE cap to train these residents, no FTE cap adjustment is needed. Thus, in order for a hospital to qualify for an adjustment to its resident-to-bed ratio cap (or 3-year rolling average count), the hospital must first qualify for a temporary adjustment to its FTE cap. To qualify for a temporary FTE cap adjustment, the hospital must demonstrate that accepting some number of displaced residents has caused the hospital to exceed its FTE cap. Therefore, the proposed resident-to-bed ratio cap adjustment is necessarily linked to ''the number of FTE residents that has caused the hospital to exceed its FTE cap.'' Accordingly, we are not accepting the commenter's request at this time. However, we may consider in the future proposing to allow hospitals that are below their FTE caps and train displaced residents to also receive an adjustment for those displaced residents that are under the cap for purposes of applying the resident-to-bed ratio cap and the 3-year rolling average. As a final note, we would like to point out an error in the example that the commenter provided. In the example, a hospital that has 4 FTEs and an FTE cap of 5, accepts 3 displaced FTE residents. The commenter stated that the current year resident-to-bed ratio would be 0.07 ((4+3)/100). This is incorrect. Since, as explained above, the regulations prescribe that the receiving hospital's FTE count is only adjusted for those FTEs that have caused the receiving hospital to exceed its FTE cap, the current year numerator (as well as the prior year numerator) would be 6 (4+2), because only 2 of the 3 FTEs have caused the hospital to exceed its FTE cap of 5 FTEs.

Comment: One commenter requested CMS to allow hospitals that train displaced residents to receive permanent, not temporary, adjustments to their FTE caps.

Response: We are not addressing this comment in this final rule because it is outside the scope of what was specifically addressed in the proposed rule.

3. Counting Beds for the IME and DSH Adjustments (§ 412.105(b) and § 412.106(a)(l)(i))

In the May 9, 2002 proposed rule, we discussed the regulations located at § 412.105(b) for determining the number of beds to be used in calculating the resident-to-bed ratio for the IME adjustment. Those regulations also are used to determine the number of beds for other purposes, including calculating the DSH adjustment at § 412.106(a)(l)(i). Section 412.105(b) specifies that the number of beds in a hospital is determined by counting the number of available bed days during the

cost reporting period and dividing that number by the number of days in the cost reporting period. The number of available bed days does not include beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units.

We also discussed section 2405.3G of Part I of the Medicare Provider Reimbursement Manual (PRM), which further defines an ''available'' bed as a bed that is permanently maintained and is available for use to lodge inpatients.

These discussions were background for our proposal to clarify some of the uncertainty that had arisen concerning the application of the definition of ''available.'' For example, a question has arisen as to whether beds in rooms or entire units that are unoccupied for extended periods of time should continue to be counted on the basis that, if there would ever be a need, they could be put into use.

Counting the number of beds in a hospital is intended to measure the size of a hospital's routine acute care inpatient operations. While hospitals necessarily maintain some excess capacity, we believe there is a point where excess capacity may distort the bed count. Therefore, we proposed to revise our policy concerning the determination of a hospital's bed size to exclude beds that represent an excessive level of unused capacity. We stated that the proposed refinement of our bed counting policy would better capture the size of a hospital's inpatient operations as described above.

We analyzed Medicare hospital data and found that, among hospitals that have between 100 and 130 beds, hospitals receiving DSH payments have lower occupancy rates than similar hospitals not receiving DSH payments. Because DSH payments are higher for urban hospitals with more than 100 beds, there may be an incentive for these hospitals to maintain excess capacity in order to qualify for those higher payments. Among 189 urban hospitals in this bed-size range that did not receive DSH payments during FY 1999, the average occupancy rate was 55 percent. However, among 294 urban hospitals in this bed-size range that did receive DSH payments during FY 1999, the average occupancy rate was 47 percent. Twenty-five percent of this group of hospitals (those receiving DSH payments) had occupancy rates below 35 percent. Among the hospitals not receiving DSH payments, 25 percent had occupancy rates below 43 percent. We believe this is indicative of a tendency among some small urban hospitals to maintain excess capacity in order to qualify for higher DSH payments. Therefore, we proposed that if a hospital's reported bed count results in an occupancy rate (average daily census of patients divided by number of beds) below 35 percent, the applicable bed count, for purposes of establishing the number of available beds for that hospital, would exclude beds that would result in an average annual occupancy rate below 35 percent (proposed § 412.105(b)(3)).

For example, if a hospital reports 105 beds for a cost reporting period, but has an average daily census of 26 patients for that same cost reporting period, its occupancy rate equals 24.8 percent (that is, 26/105). Because its occupancy rate is below the proposed minimum threshold of 35 percent, its maximum available bed count would be 74, which is the number of beds that would result in an occupancy rate of 35 percent, given an average daily census of 26 patients(that is, 26/.35).

We proposed to otherwise continue to determine a hospital's bed size using existing regulations and program manual instructions, including the application of the available bed policy.

We believe that the policy in the May 9, 2002 proposed rule more accurately indicates the size of a hospital's operations. We proposed to specify under § 412.105(b)(3) that if a hospital's reported bed count results in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent. We proposed to make the proposed policy effective for discharges occurring on or after October 1, 2002.

Comment: Numerous commenters questioned why we were interested in applying an occupancy adjustment to counting beds for IME and DSH purposes. The commenters strongly opposed the proposed policy, which they indicated would serve to increase a hospital's IME payment but would limit a hospital's bed size for DSH payment purposes, if the hospital's occupancy is below 35 percent. In addition, the commenters believed that there are other reasons why a hospital may have excess capacity that may include patients utilizing the outpatient services instead of inpatient services, and that, due to cost, patients may be moved sooner from acute care settings to the next level of care.

The commenters contended that this proposal is contrary to the statutory language and congressional intent. The commenters further contended that the proposed policy would cause financial hardship to small urban hospitals that treat a disproportionate number of low-income patients.

MedPAC indicated that it believed that we are recognizing a real problem in maintaining integrity in the DSH payment procedures. However, MedPAC believed that the proposed policy illustrates the difficulties that arise when qualifying for DSH payments depends in part on the number of beds a hospital keeps in service. MedPAC recommended that a single formula apply to all hospitals regardless of location (urban/rural) or bed size. In addition, MedPAC recommended that the low-income shares used to determine each hospital's DSH adjustment reflect all low-income patients, which include patients receiving uncompensated care. MedPAC stated that a new DSH distribution formula will be needed when the uncompensated care data are complete, and that would be an opportune time to eliminate the use of a bed standard. Based on this information, MedPAC questioned whether it is worth changing the bed counting methodology now since a more fundamental change may occur in the next year or two.

Response: We believe our proposed policy represents a reasonable approach to addressing situations where hospitals appear to be maintaining excess capacity in order to qualify for higher DSH payments. With respect to our authority to implement such a change, we point out that we have broad authority under the statute in establishing the methodology for determining the number of available beds.

However, at this time, we have decided not to proceed with the proposed change. Instead, we will consider this issue as part of a future comprehensive analysis of our bed and patient day counting policies. That is, we believe there are other aspects of counting beds that need to be addressed as well and, upon further consideration, we have decided to proceed in a more comprehensive manner. We acknowledge MedPAC's comments as well and will take into account the potential that bed counting issues for DSH purposes may become less significant.

Accordingly, in this final rule, we are not adopting the proposed change of § 412.105(b)(3).

Technical Correction

Section 211(b) of Public Law 106–554 amended section 1886(d)(5)(F)(iv)(III) of the Act to revise the calculation of the DSH payment adjustment for hospitals affected by the revised thresholds as specified in section 211(a) of Public Law

106–554. These changes were effective for discharges on or after April 1, 2001, and no changes were made by section 211(b) for discharges prior to April 1, 2001. When we issued the June 13, 2001 interim final rule with comment period (66 FR 32172) to update the regulations to incorporate the changes made by section 211, we inadvertently changed the adjustment factor for rural hospitals with fewer than 100 beds from 4 percent to 5 percent under § 412.106(d)(2)(iv)(A) for discharges occurring before April 1, 2001. We are correcting this error in this final rule by revising § 412.106(d)(2)(iv)(A) to specify that, for discharges before April 1, 2001, the applicable DSH adjustment factor for rural hospitals with fewer than 100 beds was 4 percent.

This correction was not included in the May 9, 2002 proposed rule, as we were only made aware of it after publication of that proposed rule. The Administrative Procedure Act generally requires that agency rules be published in the **Federal Register** as a notice of proposed rulemaking with a period for public comment (5 U.S.C. 533(b)). This notice-and-comment procedure can be waived, however, if an agency finds good cause that the procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. Since this change is being made to correct a technical error, we find that the notice-and-comment procedure is unnecessary, and, therefore, find good cause to waive the notice of proposed rulemaking and issue the correction in this final rule.

F. Medicare-Dependent, Small Rural Hospitals: Ongoing Review of Eligibility Criteria (§ 412.108(b))

Section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) added section 1886(d)(5)(G) to the Act and created the category of Medicare-dependent, small rural hospitals (MDHs). MDHs are eligible for a special payment adjustment under the acute care hospital inpatient prospective payment system. Initially, in order to be classified as an MDH, a hospital must have met all of the following criteria:

- The hospital is located in a rural area (as defined in § 412.63(b);
- The hospital has 100 or fewer beds (as defined at § 412.105(b)) during the cost reporting period;
- The hospital is not classified as an SCH (as defined at § 412.92); and
- The hospital has no less than 60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during its cost reporting period beginning in FY 1987.

MDHs were eligible for a special payment adjustment under the acute care hospital inpatient prospective payment system, effective for cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to SCHs, that is, based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The national Federal rate applicable to the hospital.

The updated hospital-specific rate based on FY 1982 costs per discharge.

The updated hospital-specific rate based on FY 1987 costs per discharge.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) extended the MDH provision through FY 1994 and provided that, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which the hospital-specific rate exceeded the Federal rate. The MDH provision expired effective with cost reporting periods beginning on or after October 1, 1994.

Section 4204(a)(3) of Public Law 105–33 reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise the qualifying criteria for these hospitals or the payment methodology.

Section 404(a) of Public Law 106–113 extended the MDH provision to discharges occurring before October 1, 2006.

As specified in the June 13, 2001 interim final rule with comment period (66 FR 32172) and finalized in the August 1, 2001 final rule (66 FR 39883), section 212 of Public Law 106–554 provided that, effective with cost reporting periods beginning on or after April 1, 2001, a hospital has the option to base MDH eligibility on two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, rather than on the cost reporting period that began during FY 1987 (section 1886(d)(5)(G)(iv)(IV) of the Act). According to section 1886(d)(5)(G)(iv)(IV) of the Act, the criteria for at least 60 percent Medicare utilization will be met if, in at least ''2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report'', at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits.

We would like to point out that cost reports undergo different levels of review. For example, some cost reports are settled with a desk review; others, through a full field audit. We believe the intention of the law is to provide hospitals the ability to qualify for MDH status based on their most recent settled cost reporting periods, each of which undergoes a level of audit in its settlement.

Hospitals that qualify under section 1886(d)(5)(G)(iv)(IV) of the Act are subject to the other provisions already in place for MDHs. That is, all MDHs are paid using the payment methodology as defined in § 412.108(c) and may be eligible for the volume decrease provision as defined in § 412.108(d).

Under existing classification procedures at § 412.108(b), a hospital must submit a written request to its fiscal intermediary to be considered for MDH status based on at least two of its three most recently audited cost reporting periods for which the Secretary has a settled cost report (as specified in § 412.108(a)(1)(iii)(c)). The fiscal intermediary will make its determination and notify the hospital within 90 days from the date it receives the hospital's request and all of the required documentation. The intermediary's determination is subject to review under 42 CFR part 405, Subpart R. MDH status is effective 30 days after the date of written notification of approval.

In the May 9, 2002 proposed rule, we proposed to clarify and to codify in the regulations (proposed § 412.108(b)(4)) that an approved classification as an MDH remains in effect unless there is a change in the circumstances under which the classification was approved. That is, in order to maintain its eligibility for MDH status, a hospital must continue to be a small (100 or fewer beds), rural hospital, with no less than 60 percent Medicare inpatient days or discharges during either its cost reporting period beginning in FY 1987 or during at least two of its three most recently settled cost reporting periods.

We also proposed to clarify and to codify in the regulations (proposed § 412.108(b)(5)) that the fiscal intermediary will evaluate on an ongoing basis whether or not a hospital continues to qualify for MDH status. This proposed clarification included evaluating whether or not a hospital that qualified for MDH status under section 1886(d)(5)(G)(iv)(IV) of the Act continues to qualify for MDH status

based on at least two of its three most recently settled cost reporting periods.

In addition, we proposed (proposed § 412.108(b)(6)) that if a hospital loses its MDH status, that change in status would become effective 30 days after the fiscal intermediary provides written notification to the hospital that it no longer meets the MDH criteria. If the hospital would like to be considered for MDH status after another cost reporting period has been audited and settled, we proposed to require that the hospital must reapply by submitting a written request to its fiscal intermediary (proposed § 412.108(b)(7)). An MDH that continues to meet the criteria would not have to reapply.

Comment: Three commenters addressed our proposal to conduct ongoing reviews of hospitals to determine whether or not they continue to meet the MDH criteria. The first commenter opposed the proposal for ongoing reviews of MDHs because this type of review is not specified in the law, but is an interpretation by CMS. The commenter supported its position by pointing out that a hospital qualifying based on the original criterion (that is, 1987 data) is allowed to retain this status despite any changes in subsequent years. The commenter also stated this may cause instability in individual hospital payments from year-to-year, which will be disruptive for a hospital whose revenue depends heavily on Medicare. The commenter suggested that, if the proposed reviews are found to be consistent with Congressional intent, CMS adopt a policy that does not penalize hospitals for small changes in patient mix and provides stability in the payment system from year to year. Moreover, the commenter suggested granting MDH status for a 3-year period before requiring requalification, similar to wage index reclassifications, or setting the level for requalification at a slightly lower level (perhaps 55 percent) so that a slight change in volume does not cause a loss of MDH status.

The second commenter supported the proposal but recommended that the requirement that hospitals apply for MDH status be removed, since the fiscal intermediaries will be conducting annual reviews.

The third commenter focused on the loss of MDH status effective 30 days after the intermediary provides written notification to the hospital that it no longer qualifies for MDH status. The commenter stated that mid-year MDH status changes provide a number of claims processing and cost report settlement problems. The commenter recommended that the effective date for the change in MDH status should be the first day of the cost reporting period following the intermediary's notification of the hospital.

Response: We agree that hospitals that qualify based on the original criteria were not required to requalify based on more recent data, since the original criteria, as dictated by law, was based on a specified period, here the 1987 data. However, the law was amended and specifies the new, additional criterion: ''two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report.'' We believe this language supports an interpretation that a hospital is to qualify as an MDH based on its most recent data, not based on a one-time qualification, as is the case with the original criteria (which was based on data from a set period of time, the hospital's FY 1987 cost reporting period).

With respect to the suggestion that the proposed ongoing reviews of hospitals MDH status should provide that, once approved, retention of a hospital's MDH status for a 3-year period, or that the level for requalification should be at a slightly lower percentage of inpatient days or discharges attributable to Medicare than 60 percent, the statute (section 1886(d)(5)(G)(iv)(IV) of the Act) does not provide such flexibility. Allowing hospitals to qualify using cost report data from other than two of the three most recently available cost reporting periods, or using a percentage less than 60 percent, would be inconsistent with the statutory language.

Regarding the effective date of a status change, the effective date of 30 days after the date of the notice from the fiscal intermediary is consistent with current policy for approval of both MDH and SCH status as well as notices that the hospital no longer meets such eligibility criteria. Concerning the commenter's request to not require hospitals to reapply for MDHs status since the intermediaries would already be reviewing that status on an annual basis, we wish to clarify that the ongoing reviews would be of hospitals with existing MDHs status only. Therefore, hospitals that had lost their MDH status would not be included in an automatic annual review to determine whether or not the hospitals continue to meet the eligibility criteria for MDH status. Instead, such hospitals must reapply for MDH status based on two of their three most recently audited cost reports.

Accordingly, we are adopting as final the proposed revised changes to the MDH policy under § 412.108(b).

G. Eligibility Criteria for Reasonable Cost Payments to Rural Hospitals for Nonphysician Anesthetists (§ 412.113(c))

Currently, a rural hospital can qualify and be paid on a reasonable cost basis for qualified nonphysician anesthetists (certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants) services for a calendar year beyond 1990 and subsequent years as long as it can establish before January 1 of that year that it did not provide more than 500 surgical procedures requiring anesthesia services, both inpatient and outpatient.

In the September 1, 1983 interim final rule with comment period that implemented the acute care hospital inpatient prospective payment system, we established the general policy to include, under that prospective payment system, inpatient hospital services furnished incident to a physician's service, with a time-limited exception for the inpatient hospital services of anesthetists (48 FR 39794). The purpose of this exception, which originally was for cost reporting periods beginning before October 1, 1986, was that the practice of physician-employer and anesthetist-employee was so widespread that we believed ''it would be disruptive of medical practice and adverse to the quality of patient care to require all such contracts to be renegotiated in the limited time available before the implementation of the prospective payment system.''

Section 2312 of Public Law 98–369 provided for reimbursement to hospitals on a reasonable cost basis as a pass-through for the costs that hospitals incur in connection with the services of CRNAs.[1] Section 2312(c) provided that the amendment was effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

Section 9320 of Public Law 99–509 (which established a fee schedule for the services of nurse anesthetists) amended section 2312(c) of Public Law 98–369 by extending the pass-through provision for cost reporting periods beginning before January 1, 1989. Section 608 of Public Law 100–485 limited the pass-through provision effective during 1989, 1990, and 1991, to hospitals meeting the following criteria:

[1] We noted in the August 31, 1984 final rule that section 2312 and the Conference Report used the term ''CRNA'' throughout. However, we believed it was Congressional intent to apply this pass-through payment amount to the services of all qualified hospital-employed nonphysician anesthetists (49 FR 34748).

• As of January 1, 1988, the hospital employed or contracted with a certified nonphysician anesthetist;

• In 1987, the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed 250 (or such higher number as the Secretary determines to be appropriate); and

• Each certified nonphysician anesthetist employed by, or under contract with, the hospital has agreed not to bill under Part B of Medicare for professional services furnished by the anesthetist at the hospital.

Subsequently, section 6132 of Public Law 101–239 amended section 608 of Public Law 100–458 by raising the established 250-procedure threshold to 500 procedures (effective for anesthesia services furnished on or after January 1, 1990), and extended the cost pass-through indefinitely. However, section 6132 of Public Law 101–239 left intact the requirement that the hospital must have not exceeded a maximum number of surgical procedures (effectively raised to 500), both inpatient and outpatient, requiring anesthesia services during 1987. Also, the statutory authority for the Secretary to adopt such other appropriate maximum threshold volume of procedures as determined appropriate was not affected by section 6132.

In light of the age of this provision, we undertook to reexamine the appropriateness of the current 500-procedure threshold. Nonphysician anesthetists who are not employed by or have a contractual relationship with a hospital paid under this provision may receive payments under a fee schedule. Payments under the fee schedule are generally somewhat lower than those made on a reasonable cost basis. Therefore, hospitals that exceed 500 procedures may have difficulty retaining access to nonphysician anesthetists' services because cost reimbursement is unavailable. According to data from the American Association of Nurse Anesthetists (AANA), the average salary for a CRNA in rural areas in calendar year 2000 was $111,000, with a total annual compensation of $141,000. The AANA estimates that, based on payments under the Medicare fee schedule, a CRNA would have to provide at least 800 anesthesia procedures to reach this average level of compensation.

The statute provides the Secretary with the authority to determine the appropriateness of the volume threshold, in part, so that changes necessary to meet the needs of rural hospitals can be made. As we have found that hospitals that exceed the 500 surgical procedures may have difficulty in retaining access to nonphysician anesthetists' services, we believe that the appropriate maximum threshold for surgical procedures should be raised in order for the payment exception to apply to those hospitals most in need of this payment treatment. Based upon the data available to us concerning the best estimates of average total compensation to a CRNA, we believe that the maximum volume threshold for surgical procedures requiring anesthesia services should be raised to 800. Therefore, to ensure continued access to nonphysician anesthetists' services in rural hospitals, in the May 9, 2002 proposed rule, we proposed to revise §§ 412.113(c)(2)(ii) and (c)(2)(iii) to raise the 500-procedure threshold to 800 procedures.

Comment: Several commenters supported our proposed changes and indicated that, without the proposed change in the regulations, rural hospitals will experience serious disruptions in their delivery of anesthesia services. CRNAs are the sole anesthesia providers in a number of rural hospitals. The commenters added that, without CRNAs, these rural hospitals will have difficulty in continuing to meet their patient's surgical and trauma stabilization services. Patients will be forced to travel outside of their communities, which could mean great distance.

One commenter suggested that the threshold should be reviewed every 3 years to ensure it continues to appropriately reflect market conditions for rural hospitals trying to maintain anesthetists services.

Response: We agree that the existing regulation providing for 500 procedures per year as a threshold could hinder the ability of some rural hospitals to sustain access to surgical procedures, which is the reason for our proposed change. We will continue to monitor this issue to determine whether future adjustments to the procedure threshold are warranted.

Comment: Several commenters raised an issue concerning the fact that some Medicare fiscal intermediaries include nonanesthesia ancillary services provided by the CRNAs when counting the total number of surgical procedures. They indicated that many rural hospitals are not able to qualify for the reasonable cost payment for their CRNAs as a result.

The commenters suggested a specific definition of surgical procedures that include cutting, abrading, suturing, and lasering of otherwise physically changing body tissues and organs. The commenters indicated that this suggested definition would clarify and eliminate the confusion in regulatory interpretation across fiscal intermediaries. One commenter indicated that anesthetists may provide therapeutic services for pain management unassociated with a surgical procedure.

Response: In view of the comments on this issue, we believe that certain steps are needed to improve consistency in the counting of surgical procedures. We appreciate the commenter's recommended definition of surgical procedures, and will consider whether such instructions would reduce inconsistency in counting of procedures, while still being consistent with the legislative and regulatory intent of this provision. We also will review all aspects of the counting of procedures to consider what further actions may be necessary to improve consistency. Our goal is to facilitate greater consistency in the manner and criteria used by all intermediaries.

Comment: Several commenters expressed concern that the existing regulations only allow hospitals in existence as of 1987 to qualify for reasonable cost pass-through and requested us to review this issue. The commenters indicated that this threatens new rural hospitals' ability to continue to provide surgical and anesthesia services to patients.

Response: To enable rural hospitals to secure anesthesia services for their patients, these regulations include a rural hospital's option for reasonable cost pass-through for the services of one full-time equivalent CRNA, as long as the hospital qualifies for ''pass-through'' treatment. The statute specifies the criteria and the regulation tracks the statutory language. Therefore, we believe we do not have the authority to extend this provision to hospitals that do not otherwise meet the criteria as described by the statute.

Comment: Some commenters sought clarification as to whether this provision is available to SCHs.

Response: SCHs that otherwise meet the statutory criteria are eligible to receive this pass-through payment. We are not aware that there has been any confusion in the past on this issue, but we are clarifying the point here in response to the comment.

Comment: Several commenters recommended that we eliminate the threshold altogether, or raise it even higher. One commenter stated that the need for the pass-through demonstrates that fee schedule payments for nonphysician anesthetists are inadequate to defray the costs associated with this service.

Another commenter suggested that CAHs should be exempt from the qualifying criteria to receive these pass-through payments. The commenter suggested that removing this requirement for CAHs would eliminate the unnecessary paperwork required for these hospitals to demonstrate they continue to meet the minimum thresholds.

A third commenter argued that the cost pass-through provision should permit rural hospitals to qualify on the basis of employing anesthesiologists as well. This commenter referred to survey data that purported to show a serious shortage of anesthesia providers in support of this argument.

Response: As described above, we believe the statute is specific as to the threshold requirements to qualify for the CRNA pass-through payments. Accordingly, a hospital or CAH that wishes to qualify for CRNA pass-through payments must meet the statutory criteria, including the threshold requirement. We also believe the statute does not provide authority to expand this policy to pay pass-through costs to hospitals for anesthesiologists' services. We believe the change we are making, increase the threshold from 500 to 800 procedures per year, is appropriate and note that it is generally supported by the commenters.

Comment: The AANA requested a technical correction to the reference in the proposed rule that, according to data from AANA, the average total annual compensation for CRNA in 2001 is approximately $155,000. According to the AANA, the most recent data for calendar year 2000 reflect an average salary in rural areas of $111,000, with a total annual compensation of $141,000.

Response: In the preamble of this final rule, we have revised the prior reference accordingly to avoid any potential confusion.

Comment: One commenter questioned whether anesthesiologists assistants are recognized as qualified providers under this provision.

Response: As we noted in the proposed rule and in the discussion above, our understanding of Congressional intent was that this pass-through payment applied to the services of all qualified hospital-employed nonphysician anesthetists (67 FR 31464). Therefore, a hospital otherwise meeting the criteria for this pass-through payment by employing an anesthesiologists assistant would be eligible for pass-though payments.

Comment: One commenter requested clarification of whether the requirement at § 412.113(c)(2)(i)(D) that ''each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care in that hospital or CAH'' applies only to Medicare beneficiaries or to all patients.

Response: This requirement is to ensure that the nonphysician anesthetist is not also billing Medicare for Part B services under the fee schedule. Therefore, the requirement only pertains to services provided to Medicare beneficiaries. In this final rule, we are adding a revision to § 412.113(c)(2)(i)(D) to reflect the limited applicability of this requirement.

Accordingly, we are adopting as final the proposed changes to § 412.113(c)(2)(ii) and (c)(2)(iii), with one change. We are revising § 412.113(c)(2)(i)(D) to specify that each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

H. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§§ 412.230, 412.232, and 412.273)

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in Subpart L of Part 412 (§§ 412.230 *et seq.*) set forth criteria and conditions for redesignations from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

1. Withdrawals, Terminations, and Cancellations

Under § 412.273(a) of our regulations, a hospital or hospital group may withdraw its application for reclassification at any time before the MGCRB issues its decision or, if after the MGCRB issues its decision, within 45 days after publication of our annual notice of proposed rulemaking concerning changes to the acute care hospital inpatient prospective payment system for the upcoming fiscal year (for example, the May 9, 2002 proposed rule for FY 2003). In the August 1, 2001 final rule, we specified that, for purposes of implementing section 304 of Public Law 106–554, the withdrawal procedures and the applicable timeframes in the existing regulations would apply to hospitals that receive 3-year reclassification for wage index purposes (66 FR 39886). Once effective, a withdrawal means that the hospital would not be reclassified for purposes of the wage index for FY 2003 (and would not receive continued reclassification for FYs 2004 and 2005), unless the hospital subsequently cancels its withdrawal. The procedure for canceling a withdrawal or termination is discussed in detail below.

Consistent with section 1886(d)(10)(D)(v) of the Act, a hospital may terminate its approved 3-year reclassification during the second or third years (§ 412.273(b)). This is a separate action from a reclassification withdrawal that occurs in accordance with the timeframes described above. Currently, in order to terminate an approved 3-year reclassification, we require the hospital to notify the MGCRB in writing within 45 days after the publication date of the annual proposed rule for changes to the hospital inpatient prospective payment system (§ 412.273(b)(1)(i)). A termination, unless subsequently cancelled, is effective for the full fiscal years remaining in the 3-year period.

We also provided that a hospital may apply for reclassification to a different area for the year corresponding to the second or third year of the reclassification (that is, an area different from the one to which it was originally reclassified) and, if successful, the reclassification would be for 3 years. Since the publication of the August 1, 2001 (FY 2002) final rule, we received an inquiry regarding a situation where a hospital with an existing 3-year wage index reclassification successfully reclassifies to a different area, then withdraws from that second reclassification within the allowable timeframe for withdrawals. This scenario raises several issues not specifically covered in the August 1, 2001 final rule, which we are addressing in this final rule.

For example, the question arises, at what point does a hospital's termination of a 3-year reclassification become effective when a hospital applies for reclassification to another area? As noted above, the August 1, 2001 final rule specified that a hospital must file a written request with the MGCRB within 45 days after publication of the annual proposed rule to terminate the reclassification. However, the rules do not specify at what point a previous 3-year reclassification is terminated when

a hospital applies for reclassification to another area in subsequent years. One might conclude that an application for a wage index reclassification to another area constitutes a written notification of a hospital's intent to terminate an existing 3-year reclassification. Under this scenario, however, if the application to the second area were denied, it would then be necessary for the hospital to formally cancel the termination of its reclassification to the first area to avoid a lapse in reclassification status the following year. Therefore, in the May 9, 2002 proposed rule, we proposed to clarify, in new paragraph (iii) of § 412.273(b)(2), that, in a situation where a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1. In such a case, it will not be necessary for the hospital to submit a separate written notice of its intent to terminate its existing 3-year reclassification. Of course, a hospital also may still terminate an existing 3-year reclassification through written notice to the MGCRB, regardless of whether it successfully reclassifies to a different area.

The scenario of a hospital with an existing 3-year reclassification seeking reclassification to a second area raises another issue. If the hospital's request is approved by the MGCRB, but the hospital withdraws from that successful reclassification and ''falls back'' to its original 3-year reclassification, does the hospital retain the right to cancel that withdrawal the next year? In this way, a hospital could accumulate multiple reclassification options from which it could choose in any given year through canceling prior withdrawals or terminations to one area and withdrawing or terminating reclassifications to other areas.

We do not believe section 304 of Public Law 106–554 was intended to be used in such a manner. Therefore, in the May 9, 2002 proposed rule, we proposed to clarify existing policy that a previous 3-year reclassification may not be reinstated after a subsequent 3-year reclassification to another area takes effect. This means that a hospital that is reclassified to an area for purposes of the wage index may have only one active 3-year reclassification at a time. Once a 3-year reclassification to a second area becomes effective, a previously terminated 3-year reclassification may not be reinstated by terminating or withdrawing the reclassification to the second area and then canceling the termination or withdrawal of the reclassification to the first area.

As we stated in the August 1, 2001 final rule, we believe the 3-year wage index reclassification policy was intended to provide consistency and predictability in hospital reclassifications and the wage index. Allowing hospitals multiple reclassification options to choose from would create a situation where many hospitals move in unpredictable ways between the proposed and final rules based on their calculation of which of several areas would yield the highest wage index. This would reduce the predictability of the system, hampering the ability of the majority of hospitals to adequately project their future revenues. Therefore, in the May 9, 2002 proposed rule, we proposed to amend § 412.273(b)(2)(ii) to provide that, once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, even within 3 years from the date of such withdrawal or termination. We also proposed a technical correction to § 412.273(b)(2)(i) to correct the terminology regarding canceling (rather than terminating) a withdrawal.

Finally, the August 1, 2001 final rule did not specifically describe the process to cancel a withdrawal or termination. Therefore, in the May 9, 2002 proposed rule, we proposed to add a new § 412.273(d) (existing paragraph (d) would be redesignated as paragraph (e)) to describe the process whereby a hospital may cancel a previous withdrawal or termination of a 3-year wage index reclassification. Specifically, a hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than the deadline for submitting reclassification applications for reclassifications effective at the start of the following fiscal year (§ 412.256(a)(2)).

We did not receive any comments on these proposed changes. Therefore, in this final rule we are adopting the proposed changes as final.

2. Effect of Change of Ownership on Hospital Reclassifications

Sections 412.230(e)(2)(ii) and 412.232(d)(2)(ii) provide that, for reclassifications effective beginning FY 2003, a hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

As discussed in the August 1, 2001 final rule, we received a comment suggesting that, for purposes of calculating the 3-year average hourly wages, we permit a hospital that has changed ownership the option of excluding prior years' wage data submitted by a previous owner in order for the new hospital to qualify for reclassification. Although we responded to the comment in the August 1, 2001 final rule (66 FR 39890), we have now determined that there is a need to clarify further our policy regarding change of ownership and hospitals that do not accept assignment of the previous owner's provider agreement.

In our response to the comment, we stated that, where a hospital has changed ownership and the new owners have acquired the financial assets and liabilities of the previous owners, all of the applicable wage data associated with that hospital are included in the calculation of its 3-year average hourly wage. Where the new hospital does not claim the financial assets or assume the liabilities of a predecessor hospital, the wage data associated with the previous hospital's provider number would not be used in calculating the new hospital's 3-year average hourly wage.

Section 489.18(c) provides that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner when the parties agree to accept assignment of the provider agreement. Our regulations at § 412.230(e)(2) do not specifically address the situation of new hospitals seeking to reclassify for wage index purposes, in light of the requirement that reclassification is based on a 3-year average hourly wage. Therefore, as we proposed in the May 9, 2002 proposed rule, in this final rule we are revising § 412.230(e)(2), by adding a new paragraph (e)(2)(iii), to clarify our existing policy to specify that, in situations where a hospital does not accept assignment of the existing hospital's provider agreement under § 489.18, the hospital will be treated as a new hospital with a new provider number. In that case, the wage data associated with the previous hospital's provider number will not be used in calculating the new hospital's 3-year average hourly wage. As we stated in the August 1, 2001 final rule, we believe this policy clarification is consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. Thus, we are revising § 412.230 to clarify, under new paragraph (e)(2)(iii), that once a new hospital has accumulated at least 1 year of wage data using survey data from the CMS hospital wage survey

used to determine the wage index, it is eligible to apply for reclassification on the basis of those data.

Comment: One commenter indicated that our efforts to clarify our policy regarding change of ownership create a financial incentive for new owners to go through the ''onerous and costly'' process of obtaining new provider numbers in order to obtain geographic reclassification. The commenter believed that any valid change in ownership under § 489.19 should allow a hospital the opportunity to request reclassification and that we should clarify that all payment areas impacted by the assignment of a new provider number should be consistently applied.

Response: This clarification establishes clear, predictable guidelines as to how hospitals' data will be treated for reclassification purposes. The rule was not adopted to govern provider behavior, since we cannot predict hospitals' behavior in situations where they may perceive it to be to their financial advantage to change their ownership arrangements. Rather, given the guidelines established by CMS, hospitals are free to act in their best interests.

I. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h) of the Act caps the number of residents that hospitals may count for direct GME.

Section 1886(h)(2) of the Act, as amended by section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272), and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as amended by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care and obstetrics and gynecology residents and nonprimary care residents in FY 1994 or FY 1995 have two separate PRAs: one for primary care and obstetrics and gynecology and one for nonprimary care.

Section 1886(h)(2) of the Act was further amended by section 311 of Public Law 106–113 to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Generally, section 1886(h)(2)(D) of the Act establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be revised.For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the floor PRA is 70 percent of the locality-adjusted, updated, weighted average PRA. For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, section 511 of Public Law 106–554 amended the floor PRA to equal 85 percent of the locality-adjusted, updated, weighted average PRA. PRAs that are below the applicable floor PRA for a particular cost reporting period would be adjusted to equal the floor PRA. PRAs that exceed the ceiling, that is, 140 percent of the locality-adjusted, updated, weighted average PRA, would, depending on the fiscal year, either be frozen and not increased for inflation, or be increased by a reduced inflation factor. Existing regulations at § 413.86(e)(4) specify the methodology for calculating each hospital's weighted average PRA and the steps for determining whether a hospital's PRA will be revised.

2. Determining the Weighted Average PRAs for Newly Participating Hospitals (§ 413.86(e)(5))

As stated earlier, under section 1886(h) of the Act and implementing regulations, in most cases Medicare pays hospitals for the direct costs of GME on the basis of per resident costs in a 1984 base year. However, under existing § 413.86(e)(5), if a hospital did not have residents in an approved residency training program, or did not participate in Medicare during the base period, the hospital's base period for its PRA is its first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. There must be at least three existing teaching hospitals with PRAs in the MSA for this calculation.

If there are at least three existing teaching hospitals with PRAs in the same geographic wage area (MSA), as that term is used in 42 CFR Part 412, the fiscal intermediary will calculate a PRA based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same MSA. If there are less than three existing teaching hospitals with PRAs within the new teaching hospital's MSA, effective for cost reporting periods beginning on or after October 1, 1997, the fiscal intermediary uses the updated regional weighted average PRA (determined for each of the nine census regions established by the Bureau of Census for statistical and reporting purposes) for the new teaching hospital's MSA (see 62 FR 46004, August 29, 1997). A new teaching hospital is assigned a PRA equal to the lower of its actual allowable direct GME costs per resident or the weighted average PRA as calculated by the fiscal intermediary. Using a methodology based on a weighted average ensures that a new teaching hospital receives a PRA that is representative of the costs of training residents within its specific geographic wage area.

Under existing policy, to calculate the weighted average PRA of teaching hospitals within a particular MSA, the fiscal intermediary begins by determining the base year PRA and the base year FTE count of each respective teaching hospital within that MSA. The weighted average PRA is (a) the sum of the products of each existing teaching hospital's base year PRA in the MSA and its base year FTEs, (b) divided by the sum of the base year FTEs from each of those hospitals. While a methodology using base year PRAs and FTEs was appropriate and workable in the years closely following the implementation of hospital—specific PRAs, it has become administratively burdensome for both CMS and the fiscal intermediaries to recreate base year information in calculating a weighted average. The methodology is particularly problematic in instances where there are large

numbers of teaching hospitals in an MSA.

In addition, as discussed in section V.I.1. of this final rule, hospitals that were training nonprimary care residents during FYs 1994 and 1995 have a distinct nonprimary care PRA, because there was no update in the inflation factor for these years (§ 413.86(e)(3)(ii)). Thus, most teaching hospitals currently have two PRAs: one for primary care and obstetrics and gynecology; and one for all other residents. (Hospitals that first train residents after FY 1995 only have a single PRA, regardless of whether they train primary care or other residents.) However, since the current methodology for calculating weighted average PRAs is based on data from FY 1984, which was prior to the years during which the PRAs were not adjusted for inflation to reflect nonprimary care residents, the methodology does not account for all PRAs (both primary care and obstetrics and gynecology and nonprimary care) within an MSA.

Accordingly, in the May 9, 2002 proposed rule, we proposed to simplify and revise the weighted average PRA methodology under § 413.86(e)(5)(i)(B) to reflect the average of all PRAs in an MSA, both primary care and obstetrics and gynecology, and nonprimary care. We proposed to continue to calculate a weighted average PRA. However, rather than using 1984 base year data, we proposed to use PRAs (both primary care and obstetrics and gynecology and nonprimary care) and FTE data from the most recently settled cost reports of teaching hospitals in an MSA. We proposed that the intermediary would calculate the weighted average PRA using the following steps:

Step 1: Identify all teaching hospitals (including those serviced by another intermediary(ies)) in the same MSA as the new teaching hospital.

Step 2: Identify the respective primary care and obstetrics and gynecology FTE counts, the nonprimary care FTE counts, or the total FTE count (for hospitals with a single PRA) of each teaching hospital in step 1 from the most recently settled cost reports. (Use the FTE counts from line 3.07, line 3.08, and line 3.11 of the Medicare cost report, CMS–2552–96,Worksheet E–3, Part IV.)

(We note that, under step 2, we have added ''line 3.11'' of the cost report to capture dental and podiatry FTE counts as part of the nonprimary care FTE counts. We made this addition in response to a comment received, as discussed below under the comment and response section for this area.)

Step 3: Identify the PRAs (either a hospital's primary care and obstetrics and gynecology PRA and nonprimary care PRA, or a hospital's single PRA) from the most recently settled cost reports of the hospitals in step 1, and update the PRAs using the CPI–U inflation factor to coincide with the fiscal year end of the new teaching hospital's base year cost reporting period. For example, if the base year fiscal year end of a new teaching hospital is December 31, 2003, and the most recently settled cost reports of the teaching hospitals within the MSA are from the fiscal years ending June 30, 2000, September 30, 2000, or December 31, 2000, the PRAs from these cost reports would be updated for inflation to December 31, 2003.

Step 4: Calculate the weighted average PRA using the PRAs and FTE counts from steps 2 and 3. For each hospital in the calculation:

(a) Multiply the primary care PRA by the primary care and obstetrics and gynecology FTEs.

(b) Multiply the nonprimary care PRA by the nonprimary care FTEs.

(c) For hospitals with a single PRA, multiply the single PRA by the hospital's total number of FTEs.

(d) Add the products from steps (a), (b), and (c) for all hospitals.

(e) Add the FTEs from step 3 for all hospitals.

(f) Divide the sum from step (d) by the sum from step (e). The result is the weighted average PRA for hospitals within an MSA.

The following is an example of how to calculate a weighted average PRA under this revised methodology:

Example

Assume that new Hospital A has a June 30 fiscal year end and begins training residents for the first time on July 1, 2003. Thus, new Hospital A's base year for purposes of establishing a PRA is the fiscal year ending June 30, 2004. New Hospital A is located in MSA 1234, in which three other teaching hospitals exist, Hospital B, Hospital C, and Hospital D. These three hospitals also have a fiscal year end of June 30 and their most recently settled cost reports are for the fiscal year ending June 30, 2000. For fiscal year ending June 30, 2000, Hospital B has 200 primary care and obstetrics and gynecology FTEs, 150 nonprimary care FTEs, and 150 nonprimary care FTEs. Hospital C has 50 primary care and obstetrics and gynecology FTEs and 60 nonprimary care FTEs. Hospital D has 25 FTEs. After updating the PRAs for inflation by the CPI–U to June 30, 2004, Hospital B has a primary care and obstetrics and gynecology PRA of $120,000 and a nonprimary care PRA of $115,000, Hospital C has a primary care and obstetrics and gynecology PRA of $100,000 and a nonprimary care PRA of $97,000, and Hospital D has a single PRA of $90,000.

(a) Primary care:
Hospital B: $120,000 × 200 FTEs = $24,000,000
Hospital C: $100,000 × 50 FTEs = $5,000,000

(b) Nonprimary care:
Hospital B: $115,000 × 150 FTEs = $17,250,000
Hospital C: $97,000 × 60 FTEs = $5,820,000

(c) Single PRA:
Hospital D: $90,000 x 25 FTEs =$2,250,000

(d) $24,000,000 + 5,000,000 + $17,250,000 + $5,820,000 + $2,250,000 = $54,320,000.

(e) 200 + 50 + 150 + 60 + 25 = 485 total FTEs.

(f) $54,320,000/485FTEs = $112,000, the weighted average PRA for MSA 1234 for fiscal year ending June 30,2004.

New Hospital A's PRA would be the lower of $112,000 or its actual base year GME costs per resident.

In the May 9, 2002 proposed rule, we proposed that the new weighted average calculation would be effective for hospitals with direct GME base years that begin on or after October 1, 2002.

In addition, we are taking the opportunity to clarify the language under existing § 413.86(e)(5)(i)(B), which relates to calculating the weighted average under existing policy. Specifically, existing § 413.86(e)(5)(i)(B) states: ''The weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, *for cost reporting periods beginning in the same fiscal years* [emphasis added].'' We believe this language could be misinterpreted to imply that only those PRAs of hospitals in the same geographic wage area (MSA) *that have the same fiscal year end as the new teaching hospital* should be used in the weighted average calculation. However, the PRAs of *all* hospitals within the MSA of the new teaching hospital should be used, not just the PRAs of hospitals with the same fiscal year end as the new teaching hospital. We proposed a revision under a proposed new § 413.86(e)(5)(i)(C).

Comment: One commenter expressed concern about our proposed changes to the calculation of weighted average PRAs for new teaching hospitals. The

commenter believed that our proposed methodology is as administratively burdensome as the existing methodology, because the servicing intermediary would be required to solicit most recently settled cost report data from all other intermediaries servicing providers in the defined territory every time a new PRA needs to be calculated. As an alternative to using most recently settled cost report data, the commenter suggested that we specify a cost reporting period from which all future data can be updated (that is, cost reporting periods ending between October 1, 1998 and September 30, 1999). The commenter indicated that it would be helpful if we would provide all intermediaries with a nationwide listing of all teaching hospitals (extracted from the HCRIS and compiled in a database/spreadsheet format), including provider number, MSA number, county, PRAs, and primary and nonprimary care FTE counts from the specified cost reporting period.

Response: We understand the commenter's concerns, but we believe that using data from most recently settled cost reports results in a weighted average PRA that more appropriately reflects the pertinent dynamics of residency training in a specific geographical area. We note that the requirement to use data from all hospitals in an MSA, regardless of whether they are serviced by different intermediaries, exists even under current regulations. In addition, generally, hospitals in the same MSA either use the same fiscal intermediary or one of two fiscal intermediaries and, therefore, we do not believe that it is unreasonably difficult to obtain information from another intermediary. Furthermore, as we have done in the past, we will continue to provide assistance to the intermediaries involved in the process of calculating the weighted average PRAs. Finally, we will consider the commenter's suggestion concerning the compilation of a nationwide database.

Comment: One commenter asked whether, considering that dental and podiatry residents are also nonprimary care, the FTE count of dental and podiatry residents from line 3.11 of worksheet E–3 Part IV should be included in determining the FTE counts in step 2 of the calculation in the proposed rule (67 FR 31467).

Response: Step 2 of the proposed calculation states, ''Identify the respective primary care and obstetrics and gynecology FTE counts, the nonprimary care FTE counts, or the total FTE count (for hospitals with a single PRA) of each teaching hospital in step 1 from the most recently settled cost reports. (Use the FTE counts from line 3.07 and line 3.08 of the Medicare cost report, CMS–2552–96, Worksheet E–3, Part IV).'' We agree with the commenter that the dental and podiatry FTE counts should also be included, and, therefore, we are revising step 2 in the example in this final rule to state that intermediaries should use the FTE counts from line 3.07, line 3.08, and line 3.11 of the Medicare cost report.

Accordingly, in this final rule, we are adopting as final the proposed revised § 413.86(e)(5)(i)(B) and the proposed new § 413.86(e)(5)(i)(C) without modification.

3. Aggregate FTE Limit for Affiliated Groups (§§ 413.86(b) and (g)(7))

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to permit hospitals flexibility in structuring rotations within a combined cap when they share residents' time. Consistent with the broad authority conferred by the statute, we established criteria for defining an ''affiliated group'' and an ''affiliation agreement'' in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). Because we had received many inquiries from the hospital industry on this policy, we proposed in the May 9, 2002 proposed rule to clarify in regulations the requirements for participating in an affiliated group. Most of these requirements are explicitly derived from the policy explained in the August 29, 1997 and May 12, 1998 final rules.

Specifically, we proposed to add under § 413.86(b) a new definition of ''Affiliation agreement.'' Under this new definition, we proposed to specify that an affiliation agreement is a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group (as defined in § 413.86(b)), that specifies—

- The term of the agreement, which, at a minimum must be one year, beginning on July 1 of a year.
- Each participating hospital's direct and indirect FTE cap.
- The annual adjustment to each hospital's FTE caps, for both direct GME and IME. This adjustment must reflect the fact that any positive adjustment to one hospital's direct and indirect FTE caps must be offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount.
- The names of the participating hospitals and their Medicare provider numbers.

In addition, we proposed to add a new § 413.86(g)(5)(iv) and a new § 413.86(g)(7) to clarify the requirements for a hospital to receive a temporary adjustment to its FTE cap through an affiliation agreement. (Existing § 413.86(g)(5)(iv) through (vi) were proposed to be redesignated as § 413.86(g)(5)(v) through (vii), respectively; and existing §§ 413.86(g)(7) through (g)(12) were proposed to be redesignated as §§ 413.86(g)(8) through (g)(13), respectively, to accommodate these additions.) Specifically, we proposed that a hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules, to reflect residents added or subtracted because the hospital is participating in an affiliated group (as that term is defined under § 413.86(b)). Under the proposed provision—

- Each hospital in the affiliated group must submit the affiliation agreement (as that term is proposed to be defined under § 413.86(b)), to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.
- There must be a rotation of a resident(s) among the hospitals participating in the affiliated group during the term of the affiliation agreement, such that more than one of the hospitals counts the proportionate amount of the time spent by the resident(s) in their FTE resident counts. (However, no resident may be counted in the aggregate as more than one FTE.) This requirement is intended to ensure that the participating hospitals maintain a ''cross-training'' relationship during the term of the affiliation agreement.
- The net effect of the adjustments (positive or negative) on the affiliated hospitals' aggregate FTE cap for each affiliation agreement must not exceed zero.
- If the affiliation agreement terminates for any reason, the FTE cap for each hospital in the affiliated group will revert to the individual hospital's pre-affiliation FTE cap.

Except for the proposed new § 413.86(g)(7)(iv) regarding the treatment of FTE caps after termination of the affiliation agreement, each provision of proposed new § 413.86(g)(7) was explicitly derived from policy stated in the May 12, 1998 final rule (63 FR 26336). We proposed

to incorporate in regulations policy that was previously established under the formal rulemaking process.

We proposed a change in policy concerning what happens to each participating affiliated hospital's FTE cap when an affiliation agreement terminates (proposed new § 413.86(g)(7)(iv)). In the preamble of the May 12, 1998 final rule (63 FR 26339), we stated: ''Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves, or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement for purposes of applying the FTE cap on an aggregate basis. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the indirect and direct medical education FTE count from each hospital's cost reporting period ending in 1996 and the cap will not be applied on an aggregate basis.'' Our purpose for allowing hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of an affiliation was to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement. However, in practice, very few hospitals have altered their FTE caps following termination of affiliation agreements. Rather, in virtually every agreement, hospitals opted to revert to their respective 1996 FTE caps upon the termination of an affiliation. In addition, we have found that our existing policy is susceptible to abusive practices that do not comport with our original purpose for allowing redistribution of FTE caps among hospitals following termination of an affiliation agreement. We have learned of a number of instances in which one hospital (Hospital A) affiliated with another hospital (Hospital B) in anticipation of Hospital B's closure at some point during the residency program year. In these instances, the affiliation agreement was made solely for the purpose of obtaining a permanent adjustment to Hospital A's FTE cap through the terms of the termination clause. As we explained in the preamble to the May 9, 2002 proposed rule, we do not believe these permanent FTE cap adjustments that result from hospital closures (or any other circumstances) were intended when Congress passed the provision on affiliation agreements. As stated above, we believe affiliations were meant to provide flexibility for hospitals in the rotations of residents where, in the normal course of an affiliation between two or more hospitals, the actual number of residents training at each hospital may vary somewhat from year to year. Affiliations were not intended to be used as a vehicle for circumventing the statutory hospital-specific FTE cap on the number of residents. In addition, we have separately addressed issues that arise when residents are displaced because of a hospital closure. We have in place a policy at existing § 413.86(g)(8) (which was proposed to be redesignated as § 413.86(g)(9) in the May 9, 2002 proposed rule) that permits temporary FTE cap adjustments for hospitals that take on the training of residents displaced by the closure of another hospital.

Therefore, in the May 9, 2002 proposed rule, we proposed that, effective October 1, 2002, for hospitals with affiliation agreements that terminate (for any reason) on or after that date, the direct and indirect FTE caps for each hospital in the affiliated group will revert back to each individual hospital's original FTE cap prior to the affiliation (proposed new § 413.86(g)(7)(iv)). This policy would not preclude the participating hospitals from entering into additional affiliation agreements for later residency years.

Since the proposed policy would be effective for agreements that terminate on or after October 1, 2002, hospitals that have already received a permanent FTE cap adjustment from their fiscal intermediaries through the existing termination clause policy would retain those cap adjustments.

We also proposed to make a conforming clarification at § 412.105(f)(1)(vi) for purposes of IME payments.

Definition of ''Affiliation Agreement'' and the Requirements at Revised § 413.86(g)(7)

Comment: Several commenters were concerned about our requirement at proposed § 413.86(b) in the definition of ''affiliation agreement'' that the agreement specify FTE cap adjustments based on a 12-month period that begins July 1 and ends June 30. Many commenters believed that the requirement should be changed so that hospitals may execute affiliation agreements at any time during the year. One commenter believed that since, regardless of the date it is executed, the resident count set forth in the agreement must be reconciled with the hospital's cost reporting period, permitting hospitals to execute agreements throughout the year would reduce the hospital's administrative burdens without imposing much, if any, additional hardship on Medicare program administration. Another commenter suggested that CMS could delay the filing date for affiliations from July 1 until either the first day of a hospital's next cost reporting period beginning after commencement of the July 1 residency period, or October 1, whichever time period is longer.

Response: We set a July 1 deadline for submission of affiliation agreements (proposed § 413.86(g)(7)(i)), as well as specifications of FTE cap adjustments in the affiliation agreements, based on the July 1 residency training year because we believed that choosing one date was administratively less burdensome to our fiscal intermediaries for purposes of audit of the participating hospitals' Medicare cost reports. In addition, we chose July 1 because we believe that date is the start date of virtually all residency training programs across all specialties. We would be more sympathetic to the commenters' request for changes in the execution date if we had heard of residency training programs that begin on dates other than July 1. Until we hear of specific programs that begin on other than July 1, we continue to believe that it is appropriate and consistent with efficient administration of the Medicare program to maintain the existing policy based on the July 1 residency training program year. We believe that it is not only less burdensome for our fiscal intermediaries (as well as CMS) to receive affiliation agreements at one point in the year alone, but we also believe it is less burdensome to participating hospitals. We believe that the vast majority of participating hospitals will know prior to July 1 how many residents will be training at the hospital in any given residency program year and how many residents would be rotating in from other hospitals.

Comment: One hospital commenter described a situation in which its existing affiliation agreement with another hospital, which was submitted to the fiscal intermediary with a copy to CMS (at that time HCFA) Central Office on July 1, 1998, states that the affiliation agreement ''shall continue in effect on an indefinite basis until terminated by the agreement of all Hospitals * * * of the affiliated group.'' The commenter asked us whether this term language meets the requirements in the proposed rule.

The same commenter mentioned that its affiliation agreement from 1998 does not specify each participating hospital's direct and indirect FTE cap, ''as this was not required in the August 29, 1997,

and May 12, 1998 final rules.'' In addition, the commenter asked whether changes in a hospital's FTE caps can be accounted for under the proposed rule. Finally, the commenter asked whether documents other than the affiliation agreement, such as attachments to the affiliation agreement, can be used to identify a hospital's direct and indirect FTE caps.

Response: As we proposed at § 413.86(b), each affiliation agreement should specify the term of the agreement ''which at a minimum is one year,'' beginning on July 1 of a year. We stated similarly in the May 12, 1998 final rule on affiliation agreements (63 FR 26341) that ''each agreement must be for a minimum of one year.'' However, there is nothing to prohibit affiliation agreements from being automatically renewable each year or from being for terms greater than one year in length. Therefore, the language that the commenter apparently used in its affiliation agreement would meet existing Medicare policy on affiliation agreements and their effectiveness. As long as the affiliation agreements cover a period of time of at least one year beginning July 1 of a year, the affiliation agreements meet the term requirement at § 413.86(b).

To address the commenter's statement that it did not report the direct and indirect GME FTE caps for the participating hospitals in its affiliation agreement because it was not previously required to do so, we stated clearly in the May 12, 1998 interim final rule that hospitals must specify the ''planned changes to individual hospital counts under an aggregate FTE cap'' (63 FR 26341). Although, under existing policy, hospitals might have reported ''planned changes'' to FTE caps in a number of ways, there is no question that they were required to do so. The revised requirements at § 413.86(b) specify that the hospital must include in the affiliation agreement each participating hospital's direct and indirect GME FTE caps in effect prior to the affiliation. The reason for requiring that affiliation agreements specify the direct and indirect FTE caps for participating hospitals is so that all hospitals will report the ''planned changes'' in the same way, allowing for ease of administration for CMS and fiscal intermediaries.

We also understand that some hospitals qualify for other FTE cap adjustments, such as those for new programs under § 413.86(g)(6)(ii). Hospitals would report their most current FTE caps in effect in the period immediately prior to the effective date of the affiliation for both direct GME and indirect medical education, so that the caps are reflective of the other FTE cap adjustments.

To respond to the commenter's question about whether attached documents to the affiliation agreement will suffice to identify direct and indirect GME FTE caps, we believe attached documents would be adequate, so long as they are considered part of the overall package of the affiliation agreement. We have stated repeatedly to the provider community that affiliation agreements need *not* be lengthy documents. In the past, we have received affiliation agreements that range in length from 2 pages to 30 pages. Each type of agreement (short or long) would be adequate as long as the affiliation agreement meets the provisions under proposed § 413.86(b).

Comment: One commenter asked how the proposed rule contemplates handling changes in the hospital's FTE adjustments if actual rotations in a given residency year turn out differently than what was stated in the affiliation agreement at the start of the residency year on July 1.

Response: We stated in the May 12, 1998 final rule (63 FR 26339) that the hospitals in the affiliated group may submit modifications to the initially reported distribution of the aggregate FTE count by June 30 of the current residency training year, if actual FTE counts for the program year are different than projected in the original agreement. While modifications to the original distribution of the aggregate FTE cap are permitted in order to allow for some fluctuations based on the actual placement of those residents within the affiliated hospitals, the overall affiliation agreement cannot be modified (for example, by adding other hospitals to increase the original aggregate cap). In most cases, we expect that the modifications to the affiliation agreements, which should be signed by all participating hospitals and submitted to the fiscal intermediary, will reflect the realities of what actually occurred as far as the number of residents that rotated in and out of each hospital during the program year. Accordingly, we would be skeptical of modifications that deviate significantly from the original affiliation agreement.

Comment: One commenter that suggested a technical change in the terminology for affiliation agreements to ''resident limit aggregation agreements'' or ''aggregation agreements.'' The commenter believed that ''affiliation agreement'' historically is a term of art in the academic community and generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs.

Response: We are aware that there has been some confusion at times among members of the provider community when using the term ''affiliation agreement,'' and we recognize that the term is utilized in contexts other than in the Medicare usage of the term for GME payment. However, we believe the Medicare use of the term is an appropriate one, rather than ''aggregation agreement'' or ''resident limit aggregation agreement.'' We note that section 1886(h)(4)(H)(ii) of the Act uses the term ''affiliated group'' and contemplates that the Secretary will define that term. Further, as we stated above, the point of the policy is that there are ''affiliations'' among the participating hospitals; that is, rotations of residents among the hospitals for purposes of applying the Medicare FTE caps. Therefore, we are not adopting the commenter's suggested technical change.

Cross-Training Requirement

Comment: Numerous commenters inquired about or addressed our proposal at § 413.86(g)(7)(ii) to clarify in regulations the requirement of a rotation of residents among the hospitals participating in every affiliated group. One commenter agreed that this requirement is appropriate in regard to nonrelated hospitals that join together in an affiliation agreement, since the cross-training is the only basis for the affiliation. However, the commenter believed it should not be applied to affiliation agreements involving only commonly owned or related hospitals because commonly owned hospitals in an affiliated group are already held to the aggregate resident cap. The commenter believed it is unnecessary and burdensome to add a further requirement that each hospital participate in a rotation to other hospitals in order to be included as part of the affiliated group.

Another commenter disagreed that this provision on cross-training between all hospitals in an affiliated group joined by common ownership is a clarification instead of a new rule. Consequently, this commenter believed the implementation of the cross-training provision should be prospective and deferred to become effective with affiliations beginning July 1, 2003. The commenter stated that if its proposal is not accepted, hospitals not in compliance should be given an opportunity to file a new affiliation agreement rather than forfeit the ability to affiliate altogether for the 2002–2003 period.

Response: We disagree with the commenter's statement that commonly owned hospitals in an affiliated group are ''already'' held to the aggregate resident cap. Hospitals are only held to an aggregate resident cap through the act of entering into a Medicare affiliation agreement, and a Medicare affiliation is not valid without the existence of a cross-training relationship. Our proposal to add an explicit cross-training requirement at § 413.86(g)(7)(ii) resulted from our belief that all hospitals that affiliate, regardless of the criteria under which they qualify to affiliate, should meet the cross-training requirement. The intent of affiliated groups is to provide flexibility within the FTE caps to hospitals that have a rotational relationship; affiliated groups are not meant to serve as a mechanism for circumventing the FTE caps. However, we acknowledge that the existing definition of ''affiliated group'' at § 413.86(b) is silent with respect to whether the cross-training requirement applies to hospitals that affiliated based on the common ownership criterion.

Nevertheless, we emphasize that the proposed cross-training requirement is derived from a broad-based cross-training policy expressed in previous final rules applying to all affiliated groups, including hospitals affiliated under common ownership. Specifically, in the May 12, 1998 final rule (63 FR 26336) we state, ''The criteria we established to determine whether two or more hospitals qualify to be an affiliated group were designed to identify hospitals that have relationships for training residents and to allow those hospitals to continue to have the flexibility to rotate residents under an aggregate FTE cap.'' Further, we initially amended the definition of an affiliated group at § 413.86(b) (63 FR 26337) to include hospitals under common ownership in response to a commenter's statement that hospitals under a single health care system ''* * * functionally operate coordinated and centrally controlled GME programs and often *rotate their residents among their various facilities* depending on training needs and other considerations'' (emphasis added). Finally, we state, ''A hospital will be permitted to engage in multiple agreements with different hospitals, as illustrated below. For example, hospital A can have an agreement with hospital B for an internal medicine program and another agreement with hospital C for emergency medicine. Although hospitals B and C do not have an agreement for any program, the affiliated group is A, B, and C; that is, the FTE resident counts at hospitals A, B, and C cannot exceed the sum of the combined caps for the three hospitals'' (63 FR 26338–26339).

Therefore, to be consistent with the cross-training requirement we proposed at § 413.86(g)(7)(ii), we are adding a reference to the cross-training requirement in paragraph (3) of the definition of ''affiliated group'' under § 413.86(b). However, because our existing definition of affiliated group did not explicitly state the cross-training requirement for hospitals that affiliate based on common ownership, we recognize that our policy may have been subject to misinterpretation. Therefore, we are making this cross-training requirement for hospitals under common ownership effective for affiliation agreements beginning July 1, 2003, the date of the first training year beginning after publication of the final regulation. Accordingly, hospitals that have affiliated under the common ownership criterion but have not met, or currently are not meeting, the rotational requirement are not required to meet the cross-training requirement until July 1, 2003.

We also address the application of the cross-training requirement at § 413.86(g)(7)(ii) to the other bases for affiliation listed in the definition of ''affiliated group'' at existing regulations at § 413.86(b). Concerning hospitals located in the same urban or rural area or in contiguous areas, we believe that application of the cross-training requirement is explicit in existing policy and not a change. We believe that the existing regulations clearly express the cross-training requirement that residents must rotate among hospitals within the affiliated group during the course of the program. Paragraph (1) of the existing definition states that hospitals may qualify as an affiliated group if the hospitals are in the same urban or rural area or in contiguous areas, and ''if individual residents work at each of the hospitals during the course of the program.'' However, to maintain consistency, we are revising the language under paragraph (1) of the definition of an ''affiliated group'' to reference the new cross-training language at § 413.86(g)(7)(ii).

The language in paragraph (2) of the existing definition of ''affiliated group'' comes from the May 12, 1998 final rule (63 FR 26358). When we issued this language at existing paragraph (2) regarding affiliations of hospitals that are jointly listed as the sponsor of a program, we did not explicitly restate the cross-training requirement because it was assumed that these hospitals, by virtue of joint sponsorship, already meet the cross-training requirement. However, to be consistent, and to further emphasize that the cross-training requirement applies to *all* affiliating hospitals, we are also adding an explicit cross-training requirement at paragraph (2) in the definition of ''affiliated group'' under § 413.86(b) by referencing § 413.86(g)(7)(ii).

Comment: One commenter stated that our requirement concerning the cross-training of residents within an affiliated group is unwarranted due to the establishment of a single FTE cap for each hospital, rather than program-specific FTE caps for each hospital. The commenter contended that hospitals that agree to affiliate should be allowed to manage training of residents in a manner that ensures the most appropriate training is received, even if this means that there is no cross-training of residents. The commenter included the following example:

AB Health system operates a pediatrics program and a geriatrics program in two hospitals, A and B. Individual hospital 1996 FTE caps were established at 10 FTEs for Hospital A and 10 FTEs for Hospital B. Historically, residents in both programs rotated between both hospitals. In 2002, the programs were reorganized so that Hospital A now specializes in pediatrics and Hospital B now specializes in geriatrics, and as a result, the hospitals no longer cross-train residents. Hospital A currently trains 12 pediatric FTEs and Hospital B currently trains 8 geriatric FTEs.

The commenter explained that the cross-training requirement would effectively reduce the number of residents Medicare will recognize AB Health System in 2002 by 2 FTEs less than the number in 1996. The commenter asserted that, accordingly, the cross-training requirement is inconsistent with our establishment of one overall FTE cap per hospital.

Response: As we stated above, the provision for affiliated groups was included by Congress to accommodate hospitals that have an existing rotational relationship. It was understood that because of the movement of residents between hospitals, the number of residents at each hospital could vary each year. Therefore, because of these existing rotational arrangements, Congress intended to allow hospitals to aggregate and modify the FTE caps on a temporary basis. We do not believe it is appropriate to allow hospitals that do not have a rotational relationship to aggregate their FTE caps simply as a means of maximizing their Medicare reimbursement. However, we note, as we have stated above, hospitals that

affiliate under the common ownership criteria do not have to meet the cross-training requirement until July 1, 2003.

We emphasize again that the cross-training requirement for affiliations is not a new concept in policy regarding Medicare affiliated groups. Indeed, the May 12, 1998 final rule repeatedly stated the idea that the policy was established in order to ''allow those hospitals to continue to have the flexibility to rotate residents under an aggregate FTE cap'' (63 FR 26336). However, because much confusion or concern has been expressed in numerous inquiries and among several commenters about the proposed clarification of the cross-training requirement, particularly when it relates to the common ownership scenario, we are amending our regulations to further specify how the cross-training requirement will be applied in each of the scenarios for affiliated groups, including common ownership. Specifically, we are revising § 413.86(g)(7)(ii) to read as follows:

> Each hospital in the affiliated group must have a shared rotational arrangement, as defined in § 413.86(b), with at least one other hospital within the affiliated group, and all the hospitals within the affiliated group must be connected by a series of such shared rotational arrangements.

We are specifying here and also at § 413.86(b) that ''shared rotational arrangement'' means a residency training program under which a resident(s) participates in training at two or more hospitals in that program. If residents rotate from one hospital to another at some point during the period of years required to complete training in a particular program, those hospitals have a ''shared rotational arrangement.'' In addition, all the hospitals within the affiliated group must be connected by a series of shared rotational arrangements. In other words, in order for the cross-training requirement to be met, there must be, at a minimum, a ''chain'' of rotations occurring from one hospital to the next within the affiliated group. For example, assume Hospitals A, B, C, and D form an affiliated group. Hospital A and Hospital B both train residents in an internal medicine program. In addition, Hospital B trains surgery residents, who also spend time training at Hospital C. Hospital C and Hospital D both operate an anesthesiology program and anesthesiology residents train in both Hospital C and Hospital D. Thus, Hospitals A and B, Hospitals B and C, and Hospitals C and D are connected by a series of shared rotational arrangements. This arrangement meets the cross-training requirement. All hospitals do not have to cross-train residents; this means that Hospital A does not have to send residents to Hospital B, Hospital C, and Hospital D, nor does Hospital B have to send residents to Hospital A, Hospital C, and Hospital D, nor does Hospital C have to send residents to Hospital A, Hospital B, and Hospital D, etc. A continuous linear chain is sufficient.

In another example of a ''shared rotational arrangement,'' Hospital A and Hospital B affiliate and they both offer training in family practice. If, at some point during the 3 years required to complete the family practice program, residents rotate from either Hospital A to Hospital B, Hospital B to Hospital A, or back and forth between Hospital A and Hospital B, then Hospital A and Hospital B have a ''shared rotational arrangement.'' Hospitals A and B may meet the definition of a ''shared rotational arrangement'' by rotating residents for a portion of a particular program year (PGY), or by rotating residents for an entire program year, so long as the family practice residents spend time at both hospitals to complete their training in family practice. For example, family practice residents may spend 3 months of their PGY1 at Hospital A and 9 months at Hospital B, or, the residents may spend their entire PGY1 training at Hospital A, and spend their entire PGY2 and PGY3 training at Hospital B. In either case, Hospital A and Hospital B have a shared rotational arrangement because they rotate residents over the course of a common training program.

Following are some examples of arrangements that do not meet the cross-training requirement:

- Hospitals A and B train residents at their respective hospitals but do not rotate residents between the 2 hospitals.
- Hospitals A, B, and C attest that they are aggregating their FTE caps, but only Hospitals A and B actually rotate residents between them, while Hospital C does not rotate residents to either Hospital A or Hospital B. In this scenario, Hospitals A and B may qualify as an affiliated group, but Hospital C may not be included for purposes of aggregating its FTE cap with Hospitals A and B, because Hospital C does not rotate residents with either Hospital A or Hospital B. Thus, Hospital C breaks the ''chain''; Hospital C is not connected to the other hospitals by a series of shared rotational arrangements.
- Hospitals A, B, C, and D attempt to aggregate their FTE caps. Hospitals A and B rotate residents between them, and Hospitals C and D rotate residents between them. In this scenario, Hospitals A and B may qualify as an affiliated group, and Hospitals C and D may qualify as a second affiliated group, but Hospitals A, B, C, and D may not qualify as a single affiliated group because the ''chain'' is broken by the lack of a series of shared rotational arrangements between Hospitals A or B and Hospitals C or D.

Finally, we believe that our regulations would be more consistent if we also amended the proposed definition of ''affiliation agreement'' at § 413.86(b) to require participating hospitals to specify the adjustment to each hospital's FTE counts resulting from the FTE resident's (or residents') participation in the shared rotational arrangement(s) at each hospital participating in the affiliated group for each year the affiliation agreement is in effect. We are also stating under this section that this adjustment to each participating hospital's FTE count is reflected in the total adjustments to each hospital's FTE caps under paragraph (3) of the definition for ''affiliation agreement'' at § 413.86(b). We believe this additional information will assist the fiscal intermediaries in tracking the FTE residents and ensuring that cross-training occurs in at least one program at each of the hospitals participating in the affiliated group, in accordance with the rotation requirement under revised proposed § 413.86(g)(7)(ii).

Example: Assume Hospital A has a direct GME FTE cap of 30 FTEs and an IME FTE cap of 29 FTEs. In the 2003–2004 residency year, Hospital A has an internal medicine residency program with 6 FTE residents training at Hospital A in each program year (a total of 18 FTEs). Hospital A also has a surgery residency program with 3 FTE residents training at Hospital A in each program year (a total of 9 FTEs). Note that Hospital A is not at its FTE cap for direct GME (there are 3 empty FTE slots) or IME (there are 2 empty FTE slots) in this fiscal year. Hospital A decides to rotate some of its residents over to Hospital B, which has an FTE cap of 5 FTEs for both direct GME and IME. Hospital B also rotates residents in a pediatric program to Hospital C. Hospital C has a direct GME cap of 9.5, and an IME cap of 10. The three hospitals affiliate to form an aggregate cap of 44.5 FTEs for direct GME and an aggregate cap of 44 FTEs for IME. Hospital A rotates 3 internal medicine FTEs and 1.5 surgery FTEs to Hospital B, for both direct GME and IME (for Hospitals A and B, this would be ''the adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in the shared rotational arrangement(s) at each hospital

participating in the affiliated group''). In addition, Hospital A also moves more of its FTE cap to Hospital B: an additional 3 FTEs for direct GME and 2 FTEs for IME (as noted above, these FTEs were available in Hospital A's caps), because Hospital B would like to train more residents in other specialties than can be accommodated under its own cap of 5 FTEs. Hospital B sends 0.5 FTE for GME and 1 FTE for IME to Hospital C. These produce a net decrease to Hospital A's direct GME cap of 7.5 FTEs (to equal an adjusted cap of 22.5 for direct GME) and a net decrease to its IME cap of 6.5 FTEs (to equal an adjusted cap of 22.5 for IME). The net increase to Hospital B's direct GME cap is 7.0 (to equal an adjusted cap of 12.0 FTEs for direct GME) and a net increase to its IME cap of 5.5 FTEs (to equal an adjusted cap of 10.5 FTEs for IME). The net increase to Hospital C's direct GME cap is 0.5 (to equal an adjusted cap of 10 FTEs for direct GME and the net increase to its IME cap is 1.0 FTEs (to equal an adjusted cap of 11 FTEs for IME).

Accordingly, the requirements as specified under paragraphs (2), (3), and (4) of the definition of ''affiliation agreement'' at § 413.86(b) may be met if affiliation agreements give the following information (although it may be stated in narrative form, as above), using the information for Hospitals A and B and C above:

DIRECT GRADUATE MEDICAL EDUCATION

[FTE caps]

	FTE cap	Total cap adjustment	Revised caps
Hospital A	30	-7.5	22.5
Hospital B	5	7	12
Hospital C	9.5	0.5	10
Aggregate Cap	44.5		44.5

SHARED ROTATIONAL ARRANGEMENT

	Minus	Plus
Hospital A	-4.5	
Hospital B	-0.5	4.5
Hospital C		0.5

INDIRECT MEDICAL EDUCATION

[FTE caps]

	FTE cap	Total cap adjustment	Revised caps
Hospital A	29	-6.5	22.5
Hospital B	5	5.5	10.5
Hospital C	10	1	11
Aggregate Cap	44		44

SHARED ROTATIONAL ARRANGEMENT

	Minus	Plus
Hospital A	-4.5	
Hospital B	-1	4.5
Hospital C		1

Thus, while the respective hospitals aggregate their FTE caps as a whole, and list the upward and downward adjustments to the participating hospitals' direct and indirect FTE caps, under revised paragraph (3) of the definition of ''affiliation agreement'' under § 413.86(b), the affiliation agreement must now separately list the positive and negative adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in the shared rotational arrangement(s) at each hospital participating in the affiliated group for each year the affiliation agreement is in effect (this may be different than the total effect of the affiliation on the hospital's cap).

In this final rule, we also are modifying § 413.86(g)(7) to add a new paragraph (iii) to state that, in accordance with proposed § 413.86(g)(7)(ii), during the shared rotational arrangements in the affiliation, more than one of the hospitals in the affiliated group must count the proportionate amount of the time spent by the resident(s) in their FTE resident counts, and that no resident may be counted in the aggregate as more than one FTE.

The Termination Clause

We received numerous comments concerning our proposed policy change on the effect of an affiliation termination on each participating hospital's FTE cap. We proposed that, upon termination of an affiliation, each affiliated hospital will revert back to its original FTE caps for both direct GME and IME prior to the affiliation. Many commenters urged us to reconsider the proposal and to keep the existing policy allowing for FTE cap redistribution upon affiliation termination.

Comment: Several commenters noted the Conference Report accompanying the Balanced Budget Act of 1997 (BBA) which stated that while CMS was given flexibility in implementing the resident limits, the flexibility is ''limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels.'' (H.R. Conference Report, Rept. No. 105–217, 105th Cong., 1st Sess., 1997, pp. 821–822). One commenter stated that they believe the Conference Report makes clear that the conferees understood that ''a sizeable number of hospitals elect to initiate 'as well as terminate' medical education programs over a period of time,'' and that the Conferees were ''concerned that within the principles of the cap * * * there is proper flexibility to respond to such changing needs * * *.'' These commenters believe that our policy change would therefore be contrary to Congress' wishes.

Response: As we explain above, and also in the proposed rule, existing policy allows affiliated hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of the affiliation agreement in order to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement. However, we proposed to change this policy because we believed it was susceptible to abusive practices such as the formation of affiliation agreements solely for the purpose of obtaining permanent adjustments to FTE caps. In fact, the commenters who advocated retaining the existing policy argued that this provision is needed to allow hospitals to increase their caps, when another hospital closes.

To address the commenters' belief that our proposed change is contrary to Congressional wishes, we note that the language quoted above from the Conference Agreement accompanying the BBA that the commenters use to support that assertion was actually intended to address Congress' newly enacted policy in the BBA on new residency program adjustments (see section 1886(h)(4)(H) of the Act for the statutory provision on this adjustment), rather than affiliated groups. In fact, the cited paragraph in the Conference Report starts out by stating: ''Among the specific issues that concerned the Conferees was application of a limit to new facilities, that is, hospitals or other entities which established programs after January 1, 1995.'' (Conference Report at 821). A separate provision on affiliations appears later in the Conference Report. The Report states: ''Another issue was the treatment of institutions which are members of an affiliated group. In some circumstances, the Conferees believe that the intent of this provision would best be met by providing an aggregate limit for such affiliates.'' Therefore, we believe that the language cited by the commenters was not meant to be applied to affiliated groups.

In addition, section 1886(h)(4)(H)(ii) of the Act specifies that ''The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary)'' to elect to apply the FTE cap on an aggregate basis (emphasis added). Thus, the statute granted the Secretary the discretion to promulgate regulations that specify what defines an affiliated group and when the FTE caps can be aggregated. Based on our analysis of the Conference Report language, as well as the statutory language, we believe the purpose of the affiliations provision is to provide temporary flexibility in the rotation of residents within the confines of the hospital-specific cap on the number of FTE residents. We do not believe the provision was meant to provide a vehicle for a hospital to circumvent the statutory FTE cap on the number of residents through permanent cap adjustments due to hospital closures.

Comment: Several commenters believed that the existing termination clause policy allowing for permanent cap adjustment ''is currently the only option available to retain'' resident slots due to hospitals or program closure. One commenter stated that the permanent transfer of residents through the use of affiliation agreement termination provisions allows the programs to continue to benefit the community indefinitely. Several of the commenters suggested that our existing policies specified at § 413.86(g)(8) that allow for temporary FTE cap adjustments to address hospital and residency program closure are ''short-lived'' and inadequate to address community needs.

Response: We understand that medical needs within a particular community may go unfulfilled whenever a hospital closes its doors, or even, in some communities, when a residency program closes. Our temporary FTE cap adjustments at § 413.86(g)(8) for hospital closures and also program closures are meant to address the situation of the residents who become ''displaced'' in either of the scenarios; they are not intended to address community medical needs (although, we know that in many cases, the temporary adjustments produce an incidental beneficial result to the community).

If Congress intended to provide permanent cap adjustments to address community needs because of hospital or program closures, we believe there would be such a provision in the Act. Until the law is amended to provide for such an explicit permanent adjustment to a hospital's FTE caps, we believe that our proposal for reverting back to pre-affiliation FTE caps upon affiliation termination is the proper policy.

Comment: Several commenters stated that the fact that a few hospitals abused the policy should not be a reason to make this policy change that affects all hospitals. One commenter believed that other appropriate safeguards can and should be put in place to avoid abuse. This commenter believed that abuse could be limited by requiring a hospital to have been part of the affiliated group for at least a full year prior to the termination of the agreement and not be part of temporary adjustment provided for at § 413.86(g)(8).

Response: In proposing the policy change requiring that when a Medicare affiliation agreement terminates, the hospitals' FTE caps revert to their original levels, we did not intend to target all hospitals due to the actions of, what the commenter has labeled, a few ''abusive hospitals.'' Rather, our intent was to clarify that we believe that any attempt to use affiliations to provide for a permanent increase in the FTE caps is not consistent with either the statute or Congressional intent.

As we noted in the preamble to the proposed regulations, in reviewing affiliation agreements that hospitals have submitted, we found that very few hospitals have altered their FTE caps following the termination of their affiliation agreements. Instead, they opt to revert to their 1996 base year caps. In fact, it is typically only where a hospital is about to close and there is the possibility that the hospital's FTE cap will be ''lost,'' that a termination clause is created to be used to transfer those slots to another hospital.

As stated above, section 1886(h)(4)(H)(ii) of the Act specifies that ''The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary)'' to elect to apply the FTE cap on an aggregate basis. We believe the basis of the policy on affiliations is to provide flexibility in the rotation of residents within the confines of the aggregate cap on the number of FTE residents. We do not believe this statutory provision was meant to provide a vehicle for a hospital to circumvent the statutory FTE cap on the number of residents through permanent cap adjustments due to

hospital closures. If Congress intended to provide for permanent cap adjustments to address situations where a hospital closes, we believe there would be a specific provision in the law to provide for such an adjustment.

Comment: We stated in the proposed rule (67 FR 31469), and also above, that the policy was proposed to be effective October 1, 2002, for hospitals with affiliation agreements that would terminate (for any reason) on or after that date. One commenter believed that the change should become effective with affiliations beginning, not terminating after October 1, 2002. Several other commenters agreed; they suggested that ''under no circumstances should a change be made that would retroactively affect an existing lawful agreement.'' Finally, one commenter suggested the change should apply only to agreements that were executed after the publication of the proposed rule so that, ''at least, it applies only to agreements in which the parties had notice of the anticipated change in policy.''

Response: We disagree with the commenters' suggestions. As we have stated above, we believe that the permanent FTE cap adjustment policy allows for the circumvention of the statutory caps. As such, we believe that the policy change should be applicable as soon as possible; that is, beginning with any terminations of affiliations that occur beginning with the effective date of this final rule.

We also disagree with the commenters that our policy change is ''retroactive''. If a hospital that is part of an already existing affiliated group decides for whatever reason to terminate the affiliation agreement, that termination would not retroactively affect the movement of the FTE caps back to their hospitals of origin. Rather, the reversion back to the pre-affiliation FTE caps occurs on a prospective basis after the termination has taken place.

Finally, to address the comment suggesting that the change in termination policy be effective with affiliation agreements executed after the publication of the proposed rule (which was on May 9, 2002), since the policy depends upon the action of a hospital terminating the affiliation agreement rather than executing the agreement, we believe it is more appropriate to maintain our proposed effective date. And, as we stated above, we believe the provider community is receiving adequate notice of this change in policy on terminations of affiliations through the notice and comment rulemaking process. Thus, we are adopting our proposal to require that the FTE caps for each hospital in the affiliated group will revert back to each hospital's FTE cap prior to entering into the affiliation upon termination of the affiliation.

Comment: Two commenters noted that the proposed rule stated that the FTE caps of hospitals in the affiliated group would revert back to their pre-affiliation levels upon termination. The commenters requested that, in cases where multiple hospitals enter into an affiliation agreement, but for whatever reason, one or more of the original affiliating hospitals wished to withdraw from the agreement, the remaining hospitals should be able to continue the affiliation agreement. One commenter stated that allowing affiliated groups to shrink from their original size to include only those hospitals that are interested in continuing their participation will ensure success of the affiliated group, while allowing CMS to reimburse hospitals subject to the limit of an aggregate cap. The commenter provided the following example: Hospitals A, B, and C enter into an affiliation agreement for the academic year beginning July 1, 2003. Each hospital has 1996 FTE caps of 8, respectively, which combine to equal an aggregate cap of 24. During this academic year, Hospital C decides to terminate its participation in the affiliated group. Hospital C takes back its 8 FTEs, its original FTE cap. Hospital A and Hospital B wish to continue affiliating, and Hospital A's FTE cap increases by 4 to equal 12, and Hospital B's FTE cap decreases by 4 to equal 4, for an aggregate cap of 16 FTEs.

Response: We believe the commenters may be confusing our proposal to require FTE caps of hospitals in the affiliated group to revert back to their pre-affiliation levels upon termination, with our policy with respect to hospitals that continue to affiliate. Our proposal would only preclude hospitals from using termination agreements as a means of permanently adjusting FTE caps. However, our proposal does not preclude hospitals from terminating their participation in an affiliation agreement, as long as each formerly participating hospital's respective original FTE caps are not changed as a result of the termination. Therefore, no modification to our regulations is necessary to adopt the commenters' request to allow affiliated groups to be reduced from their original size. The scenario described by the commenters is permissible under existing regulations. When a hospital withdraws from the affiliation, the equivalent amount of its pre-affiliation FTE cap is subtracted from the original aggregate cap, and reverts back to that hospital. The hospitals that wish to continue participating in the affiliation must submit a modified agreement to their respective intermediaries by June 30 of that academic year indicating the revised aggregate FTE cap, and adjustments to each hospital's caps, based only on the FTE caps of the hospitals that continue to affiliate.

Other Issues on Affiliated Groups

Comment: Two commenters requested that we remove our geographical restriction for hospitals to participate in an affiliated group; one commenter specifically requested that participants in an Osteopathic Postdoctoral Training Institution (OPTI) be permitted to participate in affiliated group without regard to geography. Two commenters requested that we change our policy at § 413.86(g)(6)(i)(D) concerning the prohibition of new teaching hospitals from participating in affiliated groups once the new residency program has been established. Another commenter asked that we define ''displaced residents'' for purposes of our policies at § 413.86(g)(8) on closed hospital and closed programs.

Response: Since these comments do not address issues that were specifically proposed in the May 9, 2002 notice of proposed rulemaking, we are not responding to these comments in this regulation.

Technical Corrections

We are making a technical change to the language under the definition of ''affiliated group'' under § 413.86(b) under paragraph (2). Paragraph (2) refers to hospitals that are jointly listed as the sponsor, primary clinical site, or major participating institution for one or more of the programs as these terms are used in the ''*Graduate Medical Education Directory, 1997–1998.*'' We note that the usage of the referenced terms has not changed in more recent publications of the Directory and is not expected to change in the future. Therefore, in this final rule, as part of our revision to the definition of ''affiliated group'' to incorporate the cross-training requirement for hospitals in an affiliation agreement, we are changing the reference to reflect use of the most current publication of that Directory.

When we issued the May 9, 2002 proposed rule, due to a typographical error, we inadvertently indicated that we proposed to make changes to § 413.86(g)(5)(iv) instead of § 413.86(g)(4)(iv) to incorporate revised provisions relating to determining the weighted number of FTE residents for hospitals that are part of the same affiliated group. As a result, we erroneously stated that we proposed to add a new paragraph under

§ 413.86(g)(5)(iv) and to redesignate paragraphs (g)(5)(iv), (g)(5)(v), and (g)(5)(vi) as paragraphs (g)(5)(v), (g)(5)(vi), and (g)(5)(vii) respectively to accommodate the new paragraph. We are correcting these errors in this final rule, We are changing the reference from § 413.86(g)(5)(iv) to § 413.86(g)(4)(iv). In addition, since we are revising § 413.86(g)(4)(iv) rather than inserting a new paragraph, there is no need to redesignate any paragraphs under § 413.86(g)(4).

4. Rotating Residents to Other Hospitals

At existing § 413.86(f), we state, in part, that a hospital may count residents training in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of *time worked at the hospital* to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Although these policies concerning the counting of the number of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions about whether residents can be counted by a hospital for the time during which the resident is rotated to other hospitals.

In the May 9, 2002 notice, we proposed clarifying that it is longstanding Medicare policy, based on language in both the regulations and the statute, to prohibit one hospital from claiming the FTEs training at another hospital for IME and direct GME payment. This policy applies even when the hospital that proposes to count the FTE resident(s) actually incurs the costs of training the residents(s) (such as salary and other training costs) at another hospital.

First, section 1886(h)(4)(B) of the Act states that the rules governing the direct GME count of the number of FTE residents ''shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.'' In the September 4, 1990 **Federal Register** (55 FR 36064), we stated that ''* * * regardless of which teaching hospital employs a resident who rotates among hospitals, each hospital would count the resident in proportion to the amount of time spent at its facility.'' Therefore, another hospital *cannot* count the time spent by residents training at another hospital. Only the hospital where the residents are actually training can count those FTEs for that portion of time. For example, if, during a cost reporting year, a resident spends 3 months training at Hospital A and 9 months training at Hospital B, Hospital A can only claim .25 FTE and Hospital B can only claim .75 FTE. Over the course of the entire cost reporting year, the resident would add up to 1.0 FTE.

We have been made aware of some instances where an urban hospital may incur all the training costs of residents while those residents train at a rural hospital, because the rural hospital may not have the resources or infrastructure to claim those costs and FTEs on a Medicare cost report. However, even in this scenario, the urban hospital is precluded from claiming any FTEs for the proportion of time spent in training at that rural hospital, or at any other hospital.

We note, however, that, consistent with the statutory provisions of section 1886(d)(5)(B)(iv) of the Act for IME payment and section 1886(h)(4)(E) of the Act for direct GME payment, a hospital may count the time residents spend training in a *nonhospital* setting if the hospital complies with the regulatory criteria at § 413.86(f)(4).

Comment: One commenter agreed that our clarification on the prohibition against a hospital counting residents training at other hospitals is one that is ''longstanding Medicare policy, based on language in both the regulations and the statute.'' As such, this commenter recommended that we amend our regulations to include this clarification as part of § 413.86(f)(2), ''rather than remain as a footnote to longstanding Medicare policy.''

Response: As we clarified in the proposed rule and also above, existing § 413.86(f) states, in part, that a hospital may count residents in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of *time worked at the hospital* to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Thus, we believe our existing regulations are already very clear that hospitals cannot count resident rotations at other hospitals; indeed, the hospital can only count residents working ''at the hospital''. However, because we continue to receive many questions on this policy, even though it is a longstanding one, in this final rule we are revising §§ 413.86(f) and 412.105(f) to explicitly prohibit the counting of residents at other hospitals.

As we stated above, and also in the proposed rule, we are aware of some scenarios where one hospital incurs the residency training costs of residents training at other hospitals. However, even in this scenario, the hospital incurring the costs of the residents at the other hospitals is precluded from claiming any FTEs for the proportion of time spent in training at the other hospitals.

Comment: One commenter stated that CMS should consider allowing hospitals to enter into agreements that would permit one hospital to claim the resident FTE time worked at another hospital as long as the hospital claiming the resident time is incurring ''all or substantially all'' of the training costs at the other hospitals, similar to the regulations specified at existing § 413.86(f)(4) for nonhospital sites.

Another commenter stated that it disagrees with our clarification concerning the situation where a teaching hospital cannot count resident rotations to nonteaching hospitals, even when the teaching hospital incurs ''all or substantially all'' of the costs and the rotation is part of the accredited program. One commenter requested that it be allowed to count the ''round time'' at another hospital. One commenter requested clarification on whether our policy that prohibits a hospital from counting residents rotating to other hospitals applies to the situation where residents rotate to hospitals not participating in Medicare, such as State-operated psychiatric facilities and hospitals located in foreign countries.

Response: We do not believe that it is consistent with the requirements at sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act to expand the policy at § 413.86(f)(4) concerning counting residents in nonhospital settings to allow hospitals to count residents training at other hospitals even if the hospitals seeking to count the residents incur ''all or substantially all'' of the costs. In fact, it is only because the statute has specifically provided for counting residents training at nonhospital sites that it is appropriate to include any resident not training at the hospital in the hospital's FTE count.

In addition, section 1886(h)(4)(A) of the Act requires the Secretary to establish rules for the computation of FTE residents in an approved medical residency training program. Furthermore, at paragraph (B) of that section, the statute requires that the regulations take into account individuals who serve as residents simultaneously with more than one

hospital. Therefore, we believe that the Secretary has the authority to allow a hospital to count only those residents actually training in that hospital. Even where the residents are training at other hospitals or foreign hospitals, it is not appropriate for the hospital to include those residents in its FTE count. Further, although the commenter refers to rotations occurring at ''nonteaching'' hospitals, we note that by virtue of the fact that residents are rotating and training at a hospital, the hospital is, by definition, a teaching hospital. In fact, each Medicare-participating hospital at which the residents are rotating over the course of the program year should be completing the direct GME and IME (if applicable) worksheets of the Medicare cost report in order to claim and receive Medicare payment for their respective portions of the FTE training time, regardless of whether the hospital incurs any costs for training those residents. Accordingly, we are not adopting the policy change suggested in these comments.

J. Responsibilities of Medicare-Participating Hospitals in Emergency Cases (EMTALA)

In the May 9, 2002 proposed rule, we presented certain proposed policies to clarify areas of the regulations under § 489.24 that implemented sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act and solicited comments from hospitals, physicians, patients, and beneficiary groups. These sections of the Act impose specific obligations on Medicare-participating hospitals that have an emergency department. These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. These provisions of the Act, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the antidumping statute.

In response to our proposals, we received approximately 600 pieces of correspondence, most of which contained multiple comments. A large number of the comments were received on the last day of the comment period for the proposed rule (July 8, 2002). Because of the number and nature of the public comments we received on our proposed clarifications and our limited timeframe for developing the final acute care hospital inpatient prospective payment system regulations for publication by the statutory deadline of August 1, we have decided, with one exception, to address the public comments and finalize the proposals in a separate document. The one proposal being finalized in this document is our proposed revision to the second sentence of § 413.65(g)(1) to clarify the application of EMTALA to provider-based entities. That proposal, and the action we are taking with respect to it, are described more fully in section V.L.2.g. (Clarification of Obligations of Hospital Outpatient Departments and Hospital-Based Entities) of this preamble.

K. Provider-Based Entities

1. Background

a. The April 7, 2000 Final Rule

Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare beneficiaries for those services.

In the April 7, 2000 **Federal Register** (65 FR 18504), we published a final rule specifying the criteria that must be met for a determination regarding provider-based status. The regulations at § 413.65(a)(2) define provider-based status as ''the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.'' The regulations at existing § 413.65(b)(2) state that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations at § 413.65(d). Among these criteria are the requirements that the main provider and the facility must have common licensure (when appropriate), the facility must operate under the ownership and control of the main provider, and the facility must be located in the immediate vicinity of the main provider.

The effective date of these regulations was originally October 10, 2000, but was subsequently delayed. Except where superseded by new legislation, § 413.65 is now in effect for new facilities or organizations for cost reporting periods beginning on or after January 10, 2001, as explained further below. Program instructions on provider-based status issued before that date, found in Section 2446 of the Provider Reimbursement Manual, Part 1 (PRM–1), Section 2004 of the Medicare State Operations Manual (SOM), and CMS Program Memorandum (PM) A–99–24, will apply to any facility for periods before the new regulations become applicable to it. (Some of these instructions will not be applied because they have been superseded by specific legislation on provider-based status, as described in section V.L.3. of this preamble).

b. Frequently Asked Questions Regarding Provider-Based Issues

Following publication of the April 7, 2000 final rule, we received many requests for clarification of policies on specific issues related to provider-based status. In response, we published a list of ''Frequently Asked Questions'' and the answers to them on the CMS website at *www.hcfa.gov/medlearn/provqa.htm.* (This document can also be obtained by contacting any of the CMS Regional Offices.) These questions and answers did not revise the regulatory criteria, but do provide subregulatory guidance for their implementation.

c. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554)

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106–554) was enacted. Section 404 of BIPA contains provisions that significantly affect the provider-based regulations at § 413.65. Section 404 includes a grandfathering provision for facilities treated as provider-based on October 1, 2000; alternative criteria for meeting the geographic location requirement; and criteria for temporary treatment as provider-based.

(1) Two-Year ''Grandfathering''

Under section 404(a) of BIPA, any facilities or organizations that were ''treated'' as provider-based in relation to any hospital or CAH on October 1, 2000, will continue to be treated as such until October 1, 2002. For the purpose of this provision, we interpret ''treated as provider-based'' to include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, existing provider-based facilities and organizations may retain that status without meeting the criteria

in the existing regulations under §§ 413.65(d), (e), (f), and (h) until October 1, 2002. These provisions concern provider-based status requirements, joint ventures, management contracts, and services under arrangement. Thus, the provider-based facilities and organizations affected under section 404(a) of BIPA are not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

These provider-based facilities and organizations are not exempt from the EMTALA responsibilities of provider-based facilities and organizations set forth at § 489.24 or from the other obligations of hospital outpatient departments and hospital-based entities in existing § 413.65(g), such as the responsibility of off-campus facilities to provide written notices to Medicare beneficiaries of coinsurance liability. These rules are not preempted by the grandfathering provisions of section 404 of BIPA because they do not set forth criteria that must be met for provider-based status as a department of a hospital, but instead identify responsibilities that flow from that status. These responsibilities become effective for hospitals on the first day of the hospital's cost reporting period beginning on or after January 10, 2001.

(2) Geographic Location Criteria

Section 404(b) of BIPA provides that those facilities or organizations that are not included in the grandfathering provision at section 404(a) are deemed to comply with the ''immediate vicinity'' requirements of the existing regulations under § 413.65(d)(7) if they are located not more than 35 miles from the main campus of the hospital or CAH. Therefore, those facilities located within 35 miles of the main provider satisfy the immediate vicinity requirement as an alternative to meeting the ''75/75 test'' under existing § 413.65(d)(7).

In addition, BIPA provides that certain facilities or organizations are deemed to comply with the requirements for geographic proximity (either the ''75/75 test'' or the ''35-mile test'') if they are owned and operated by a main provider that is a hospital with a disproportionate share adjustment percentage greater than 11.75 percent and is (1) owned or operated by a unit of State or local government, (2) a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or (3) a private hospital that has a contract with a State or local government that includes the operation of clinics of the hospital to ensure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.

These geographic location criteria will continue indefinitely. While those facilities or organizations treated as provider-based on October 1, 2000 are covered by the 2-year grandfathering provision noted above, the geographic location criteria at section 404(b) of BIPA and the existing regulations at § 413.65(d)(7) will apply to facilities or organizations not treated as provider-based as of that date, effective with the hospital's cost reporting period beginning on or after January 10, 2001. On October 1, 2002, the statutory moratorium on application of these criteria to the grandfathered facilities will expire. However, as we discussed in the May 9, 2002 proposed rule, we are providing for a further delay, as discussed below.

(3) Criteria for Temporary Treatment as Provider-Based

Section 404(c) of BIPA provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000, and before October 1, 2002, shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively once a request for a determination during that time period has been made. A request for provider-based status should be submitted to the appropriate CMS Regional Office. Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation for purposes of applying the provider-based status criteria in effect at the time the application is submitted. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based until the effective date of a CMS determination that the facility or organization is not provider-based.

The provision concerning temporary treatment as provider-based in section 404(c) of BIPA is effective only for requests filed before October 1, 2002. As explained further below, the procedures in new § 413.65(b)(3) will be followed in making any determinations of provider-based status in response to attestations submitted on or after October 1, 2002.

d. The August 24, 2001 and November 30, 2001 Published Regulations

In August 24, 2001 **Federal Register** (66 FR 44672), we proposed to revise the provider-based regulations to reflect the changes mandated by section 404 of BIPA and to make other technical and clarifying changes in those regulations. In the November 30, 2001 **Federal Register** (66 FR 59856), following consideration of public comments received on the August 24, 2001 proposal, we published a final rule that revised the provider-based regulations. However, the only substantive changes in the provider-based regulations were those required by the BIPA legislation.

2. Proposed Changes in the May 9, 2002 Proposed Rule

In the preamble to the proposed rule published on August 24, 2001 (66 FR 44709), we stated our intent to reexamine the EMTALA regulations and, in particular, to reconsider the appropriateness of applying EMTALA to off-campus locations. We announced that we planned to review these regulations with a view toward ensuring that these locations are treated in ways that are appropriate to the responsibility for EMTALA compliance of the hospital as a whole. We also pointed out that, at the same time, we want to ensure that those departments that Medicare pays as hospital-based departments are appropriately integrated with the hospital as a whole.

In addition, since the statutory grandfathering provision in the BIPA legislation remains in effect only until October 1, 2002, many hospital representatives have contacted CMS to request more guidance because they are concerned that their facilities are not in compliance with existing regulations and would not be able to continue billing as provider-based once the grandfathering provision expires. These hospital representatives are also concerned that the organizational and contractual changes needed to meet current provider-based requirements could take several months to complete. Moreover, resolution of some of the issues surrounding the provider-based regulations is needed in order to allow development of a uniform application form to enable the CMS Regional Offices to efficiently process the multitudes of requests for provider-based determinations that we expected as the grandfathering period expires.

To address the provider-based issues raised by the hospital industry and to allow for an orderly and uniform implementation strategy once grandfathering ends, in the May 9, 2002

proposed rule, we proposed the following regulatory changes:

a. Scope of Provider-Based Requirements (§ 413.65(a))

Since publication of the April 2000 final rule, we have received many questions about which specific facilities or organizations are subject to the provider-based requirements. In the ''Frequently Asked Questions'' posted on the CMS website, we identified a number of facility types for which provider-based determinations would not be made, since such determinations would not affect either Medicare payment or Medicare beneficiary liability or scope of benefits. The regulations at § 413.65(a) were further revised to incorporate the exclusion of these facility types from review under the provider-based criteria. We proposed to further revise § 413.65(a)(1)(ii) to state that provider-based determinations will not be made with respect to independent diagnostic testing facilities that furnish only services paid under a fee schedule, such as facilities that furnish only screening mammography services, as defined in section 1861(jj) of the Act, facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services. A provider-based determination is not necessary to resolve payment issues for a facility that furnishes only screening mammography because of a change made by section 104 of BIPA. That legislation, which amended section 1848(j)(3) of the Act, mandates that all payment for screening mammography services furnished on or after January 1, 2000, be made under the Medicare Physician Fee Schedule (MPFS). Under the MPFS methodology, Medicare payment for the service, regardless of the setting in which it is furnished, is set at the lesser of the fee schedule amount or the actual charge; and no Part B deductible applies. Regardless of the setting, Part B coinsurance is assessed at 20 percent of the lesser of the fee schedule amount or the actual charge. Because the status of a facility as provider-based or freestanding would not affect the amount of Medicare or Medicaid payment, the beneficiary's scope of benefits, or the beneficiary's liability for coinsurance or deductible amounts, it is not necessary to make a provider-based determination regarding facilities that furnish only screening mammography. We also proposed to revise § 413.65(a)(1)(ii) by adding a new paragraph (J) to state that we will not make provider-based determinations with respect to departments of providers (for example, laundry or medical records departments) that do not furnish types of health care services for which separate payment could be claimed under Medicare or Medicaid. (Such services frequently are referred to as ''billable'' services.) As explained more fully below, we would not make determinations with respect to these departments because their status (that is, whether they are provider-based or not) would have no impact on Medicare or Medicaid payment or on the scope of benefits or beneficiary liability under either program.

Despite the previous clarifications described above, providers, associations, and their representatives have continued to state that they are confused as to which facilities or organizations will be the subject of provider-based determinations.

In the May 9, 2002 proposed document, we proposed to further clarify the types of facilities that are subject to the provider-based rules, by making several changes to the definitions of key terms in § 413.65(a)(2). First, we proposed to revise the definition of ''department of a provider'' to remove the reference to a physician office as being a department of a provider. While a hospital outpatient department, in fact, may furnish services that are clinically indistinguishable from those of physician offices, physician offices and provider departments are paid through separate methods under Medicare and beneficiaries may be liable for different coinsurance amounts. Thus, it is essential to distinguish between these facility types, and we believe avoiding confusion on this issue requires us to remove the reference to a hospital department as a physician office.

We also proposed to revise § 413.65(a)(2) to state that a ''department of a provider'', ''provider-based entity'', or ''remote location of a hospital'' comprises both the specific physical facility that serves as the site of services of a type for which separate payment could be claimed under the Medicare or Medicaid programs, and the personnel and equipment needed to deliver the services at that facility. We proposed this change because we believed it would help to clarify that we would make determinations with respect to entities considered in their role as sources of health care services and not simply as physical locations. We also clarified that we do not intend to make provider-based determinations with respect to various organizational components or units of providers that may be designated as ''departments'' or ''organizations'' but do not themselves furnish types of services for which separate payment could be claimed under Medicare or Medicaid. Examples of components for which we would not make provider-based determinations include the medical records, housekeeping, and security departments of a hospital. Such departments do perform functions that are essential to the provision of inpatient and outpatient hospital services, but the departments do not provide health care services for which Medicare or Medicaid benefits are provided under title XVIII or title XIX of the Act, and for which separate payment therefore could be claimed, assuming certification and other applicable requirements were met, to one or both programs. Therefore, neither Medicare or Medicaid program liability nor beneficiary liability or scope of benefits would be affected by the ability or inability of these departments to qualify as ''provider-based.''

By contrast, Medicare or Medicaid payment (or both) to hospital departments that provide diagnostic or therapeutic radiology services to outpatients, or primary care, ophthalmology, or other specialty services to outpatients are affected by provider-based status, as would beneficiary liability for Medicare coinsurance amounts. Therefore, we would make provider-based determinations for these departments.

Similarly, if two acute care hospitals that have approved graduate medical education (GME) programs were to merge to form a single, multicampus hospital consisting of the main hospital campus and a remote location, it would be appropriate to make a determination as to whether the remote location is provider-based with respect to the main hospital campus. Such a determination would be needed because each hospital with an approved residency training program has its own hospital-specific cap on the number of residents (or FTE cap), its own PRA, and its own Medicare utilization used for purposes of receiving Medicare GME payments. A merger of the two hospitals would aggregate the two hospitals' individual FTE caps into a merged FTE cap under the main hospital's provider number, and would require recalculation of the hospital's PRA and a merging of these entities' respective Medicare utilization, resulting in a level of Medicare GME payment to the merged hospital that could exceed the sum of the payments that would be made to each hospital as separate entities. Thus, a provider-based determination would be appropriate and necessary in such a case, even though payment for services by both facilities,